Third Annual Report

CHILD SURVIVAL XVII

Cooperative Agreement # FHP-A-00-01-00039-00
October 2001 – September 2006

BARAY-SANTUK OPERATIONAL DISTRICT
KAMPONG THOM PROVINCE/CAMBODIA

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ABBREVIATIONS/ACRONYMS

ADRA	**Adventist Development and Relief Agency**
ADCOM	**Administrative Committee**
AD	**Associate Director**
APM	**Assistant Project Manager**
BCC	**Behavior Change and Communication**
BS	**Birth Spacing**
BSO	**Birth Spacing Officer**
BSOD	**Baray-Santuk Operational District**
BSSWR	**Baray-Santuk Sanitation & Water Resource (project)**
CBD	**Community Based Distributor**
CBDRN	**Community Based Distributor Resource Network (project)**
CC	**Commune Coordinator**
CD	**Country Director**
CHE	**Community Health Educator**
CFVI	**Child Friendly Village Initiative**
CS	**Child Survival**
CSCC	**Child Survival Coordinating Committee**
CSP	**Child Survival Project**
CRFC	**Community Representative Feedback Committee**
DIP	**Detailed Implementation Plan**
EPI	**Expanded Program of Immunization**
FD	**Finance Director**
FGI/D	**Focus Group Interview/Discussion**
FS	**Food Security**
FSNPSP	**Food Security and Nutrition Policy Support Project**
GAAP	**Generally Accepted Accounting Principles**
GTZ	**German Government**
HC	**Health Center**
HCM	**Health Center Midwife/ves**
HCMC	**Health Center Management Committee**
HGNS	**Home Gardening Nutrition Support (project)**
HIV/AIDS	**Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome**
HKI	**Helen Keller International**
HNP	**Hearth Nutrition Program**
HQ	**Head Quarters**
IEC	**Information, Education and Communication**
IFT	**Iron Folic acid Tablets**
IMCI	**Integrated Management of Childhood Illnesses**
IMR	**Infant Mortality Rate**
INGO	**International Non Govermental Organization**
KPC	**Knowledge, Practices and Coverage**
KPT	**Kampong Thom Province**
LAM	**Lactation Amenorrhea Method**

LOP	**Life of Project**
LNGO	**Local Non Government Organization**
LQAS	**Lot Quality Assurance Sampling**
M&E	**Monitoring and Evaluation**
MCH	**Mother and Child Health**
MEAO	**Monitoring Evaluation and Activity Officer**
MMR	**Maternal Mortality Rate**
MNC	**Maternal and Newborn Care**
MoH	**Ministry of Health**
MRD	**Ministry of Rural Development**
MPA	**Minimum Package of Activities**
MTE	**Mid-term Evaluation**
NERP	**Nutrition Education Rehabilitation Program**
NGO	**Non-Governmental Organization**
OD	**Operational District**
PA	**Project Advisor**
PDI	**Positive Deviant Inquiry**
PFD	**Partners For Development**
PHC	**Primary Health Care**
PHD	**Provincial Health Department**
PM	**Project Manager**
PMC	**Project Management Committee**
PNCC	**Provincial Nutrition Coordinating Committee**
PRA	**Participatory Rural Appraisal**
PROCOM	**Programs Committee**
ProCoCom	**Provincial Coordinating Committee**
PVO	**Private Voluntary Organization**
PWC	**Price Waterhouse Coopers**
RHPWG	**Reproductive Health Promotion Working Group**
RGC	**Royal Government of Cambodia**
STI/D	**Sexually Transmitted Infection/Disease**
TB	**Tuberculosis**
TBA	**Traditional Birth Attendant**
TOT	**Training Of Trainers**
USAID	**United States Agency for International Development**
VDC	**Village Development Committee**
VHV	**Village Health Volunteer**
WETL	**Women's Empowerment Through Literacy (project)**
WRA	**Women of Reproductive age**

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I MAIN ACCOMPLISHMENTS

The main accomplishments of the Child Survival XVII Project (CSP) in its third year include the monitoring done with the three LQAS surveys used to date, the expanded project monitoring system, new sustainability objectives, social marketing for birth spacing (BS), and the impact on behavior change as follows:

a LQAS

Three Lot Quality Assurance Sampling (LQAS) surveys have been conducted since the beginning of the project. LQAS workshops were conducted following each LQAS, on January 2003, August 2003 and April 2004 respectively. Each LQAS workshop was conducted in cooperation with Baray-Santuk Operational District (BSOD) Director, Operational District (OD) Mother Child Health (MCH) Director, 5 Health Center (HC) chiefs, 10 HC Midwives (HCMs) & Community Representative Feedback Committee members as participants. The objectives of the workshops are to decide on priority activities related to low performance project indicators and to find ways of improving the present achievements.

The table below is the comparison of three LQAS results. The LQAS results presented below are from three different types of respondents: Married non pregnant women and men aged 15-49, mothers with children aged 0-12 months and mothers with children aged 12-23 months. The data presented is a reflection of community health education efforts on respondents' knowledge and resulting health behavior change within the entire program and supervision areas.

Table 1.a.1 Married non pregnant women and men age 15-49 years

Indicators	2003		2004
	Jan %	Aug %	Apr %
Women who received at least two TT or more	52	54.7	51.9
Women who knew at least three modern BS methods	30.9	45.3	69.5
Woman who are using BS methods to delay or avoid pregnancy	61.9	42.1	54.3
Women who received counseling at HC and community level	43.2	39.5	80.9
Women who knew at least two ways HIV/AIDS is prevented	52.6	54.7	76.8
Men who knew at least two ways HIV/AIDS is prevented	56.8	56.8	81

Table 1.a.2 Mothers with children 0-11 months.

Indicators	2003		2004
	Jan	Aug %	Apr %
Mothers initiated breastfeeding with colostrum within the first hour after delivery	28.4	48.4	62
Mothers breastfed exclusively up to 6 months after delivery	47.9	32.2	53.4
Mother continue breastfeeding with illness	85.3	79.5	85.7
Mothers gave water to children with illness	82.1	86.5	89.1
Mothers gave food to children with illness	66.6	36.8	63.4
Babies weighed at birth within 24 hours after delivery	61.6	83.2	91.6
Pregnant women who received iron tablets	56.8	71.6	84.2

In the first two months after delivery lactating mothers received Vitamin A	43.2	67.4	84.2
Pregnant women who received prenatal care at least 2 times	42.1	69.2	63.3
Pregnant women were delivered by TBAs using clean birth kits	85.3	84.2	96.8
Women who initiated using modern BS methods within the first three months following pregnancy	12.1	15	23.4

Table 1.a.3 Mothers with children age 12-23 months

Indicators	2003		2004
	Jan %	Aug %	Apr %
Mother continue breastfeeding with illness	82.2	87.3	91.4
Mothers gave water to children with illness	89.9	82.7	89.6
Mothers gave food to children with illness	60.8	56	81.6
Mothers who gave same as usual or more fluids and food to a sick child	58.2	46.8	77.6
Children received at least one capsule of Vitamin A in the last 6 months	75.5	91.6	96.8
Children who completed immunization	47.4	73.6	77.9
Women who are using BS method to delay or avoid pregnancy	57.3	46.7	51.1

Although most of the indicators steadily improved, some actually were lower at the 2nd LQAS. When the CSP held a workshop after the 2nd LQAS, participants reviewed results by HC catchment area, and formed action plans on how to address the work in the areas with the lower results. Ideas included methods such as for each Village Health Volunteer to keep a copy of the family's immunization cards as well as the mother having the original copy. As is noted in the results above, the additional strategies and work done resulted in improved statistics for the 3rd LQAS (see details of 3rd LQAS on page 29).

b Project Monitoring

The CSP leadership reviewed the monitoring process for effectiveness and efficiency and found that because data collection did not focus mainly on the project indicators, some information was unnecessary and has caused delays and difficulties in the synthesis of data collection and monitoring the project progress. To eliminate unnecessary data collected and to get data fit to project indicators, the CSP leadership developed new simplified forms of data collection with an information flow from the TBA and VHV/CHE up to the CC if applicable, CS staff, CS leadership and country administration.

A major component of the CSP monitoring system is that in addition to baseline and end of project surveys, there is a periodic LQAS survey which is conducted every eight months. The LQAS survey questionnaires are used as tools in assessing the knowledge of the respondents and reporting healthy practices.

This periodic monitoring gives the picture of changes every eight months, upon which the results are reviewed and then strategies developed or adjusted to meet the problems identified. Often by the time problems are identified, the project is already confronting new sets of problems. As well, a monitoring system that provides observational data, either from the HCs or from staff observation, confirms the reported health practices in the LQAS surveys. CSP

leadership understands that the project monitoring has built capacity and is capable of using a more complex routine monitoring system that will enable it to identify and address problems in a timelier manner.

In addition to the HC assessments which have been conducted at the beginning of the first two phases, initiative had been taken to develop new Project Progress Monitoring tools, complementing the existing monitoring system. These new monitoring tools also will give opportunity for the staff to do direct observation and data collection on community health practices. LQAS will serve as quality measurement of community health knowledge, and Project Progress Monitoring will measure the HC and community practices.

The Project Progress Monitoring provides streamlined data from community and captures most significant data to feed the process indicators and adjustment is done accordingly to meet the indicators need. It is divided into three levels of data collection, first at the community, second with the staff level and third at the project management level. Community level data collection happens every day/activities, staff level data collection is done every week/activity while project management level is collected every month. The actual time involved for staff in the new system capered with the previous system is about the same as the forms were streamlined and similar data was collected and processed earlier.

There was some confusion in developing Project Progress Monitoring system, because of a few small differences found on versions of the project indicators in the Baseline and DIP. This issue had been reviewed and a revised set of indicators has been submitted to USAID for approval. In the mean time, the new Project Progress Monitoring system is working complementary to LQAS tools. (See Program changes, Appendices 6 and 7).

c New Sustainability Objectives

Central to the Mid-term Evaluation (MTE) was the Sustainability Action Plan Workshop conducted in Kampong Thom town on March 22-25, 2004. Participating in the workshop were ADRA Administration CSP leadership and staff, MOH partners from provincial, district and HC levels, representatives from community, representatives from World Relief, and other interested persons. Revised Sustainability Objectives are the product of the workshop. (see revised indicators on sustainability, Appendices 7 p.58)

The New Sustainability Objectives are important for the process of transferring project ownership to the community. CSP staff had developed an Action Plan for Revised Sustainability Objectives (see Appendices 8 p.60).

d Social Marketing of Birth Spacing Methods

Community Based Distributor Resources Network (CBDRN) is a project supported by ADRA Netherlands complimenting the CS project by training Phase I VHVs to be active as Community Based Distributors. The CBDs sell contraceptives pills and condoms at a small profit, using the Health Centers as their source of supply. They refer to HCs for injectables and insertion of IUD. These social marketing methods provide motivation to the VHV in continuing their volunteer work, as the project is now moving into Phase II area and beyond the project as well. HCs have reported to the BSOD Health Department an increased number of users of BS methods since introduction of this project. CBDRN will be discussed further in the Project Changes Section of this report.

e Behavior Change Communication (BCC) impact

The CSP has two major community health promotions strategies. The first one is addressing individuals through person to person education and role modeling during home visits and the second one is using BCC tools which specifically targeting large audiences. The BCC tools were developed during workshop in 2002 and 2003 and since then it have been incorporated into project field activities targeting large audiences.

Presently, two HIVAIDS awareness campaigns have been conducted in cooperation with BSOD, one Volunteer Celebration day at each HC, one breastfeeding awareness campaign, using media for showing videos, broadcasting radio shows and using role playing/drama, as well as bimonthly Mother's Club days and monthly Integrated Village Health day (starting in August 2004)

The table below suggests the impact of these campaigns on overall project indicators.

Table 1.b.1 Project Indicator Progress

Objectives	On Target	Comments/Processes
Maternal and Newborn Care		
Increase to 80%, HCMs able to provide quality basic pre-/post-natal and obstetric care.	Yes	Only HCMs who are responsible for birth spacing services have been trained on CBD supervision
80% of TBAs able to provide quality basic delivery care	Yes	92 TBAs attended training sessions which were led by HCMs and project staff. TBAs were also provided with clean birth kits. A system of follow-up is in place.
60% of pregnant women follow through with their TBA's referral.	Yes	The TBAs have referred 59 pregnant women with complications to HCs, the RH, and Kunthabopha hospital (a private charity hospital) in Phnom Penh since October 2002 to September 2004. (Confirmed by monthly TBA reports)
Increase from 10% to 35% mothers of children less than 24 months who receive prenatal care at least two times during the pregnancy from trained HCMs.	Yes	VHV/CHEs encourage mothers to attend the HC for prenatal care. When pregnant mothers bring sick children to the HC they are also given a prenatal check.
40% of pregnant women who have birth preparedness plan.	No	This indicator relates to the culture. Most people believe that if they are prepared in advance their babies will die or they will face problems during labor. Participatory qualitative research planned for this second phase may shed light on ways of countering this superstition. Meanwhile our BCC campaign, home visit and role model, will give special emphasis on this point.
Increase from 70% to 80% use of clean birth kits at deliveries	Yes	TBAs attended training sessions and ADRA provided clean birth kits for each TBA. Also follow-up is done every month on their knowledge, techniques and kits through a checklist. TBA kits were re-supplied monthly during TBA meeting at HC. The replenishment based on the utilization or number of delivery performed.
Increase from 25% to 80% children less than 24 months who were weighed at	Yes	Each TBA has been provided with a baby scale. Each TBA reports statistics every

birth.		month to the HC.
LBW protocol practiced by mothers in 50% of cases where newborns weigh less than 2500 grams.	No	This protocol produced by the project in 2003, is patterned after MoH protocol. Training for TBAs in Phase II will cover this protocol.
30 target villages have established a functioning emergency obstetric referral plan.	No	The process involving HCMC, HC and community leaders is underway and planned to complete during Phase II.
Increase from 5% to 85% WRA with children < 2 years who know at least two ways that HIV/AIDS is spread.	Yes	CCs & VHV/CHEs have been provided HIV/AIDS education. This is complemented by national programs in print, newspapers, radio and TV.
Increase from 57% (1st LQAS result) to 85% men 15-65 who know at least two ways that HIV/AIDS is spread.	Yes	CCs & VHV/CHEs have been provided HIV/AIDS education. This is complemented by national programs in print, newspapers, radio and TV.
Birth Spacing		
Increase from 33% to 60% women receiving birth spacing methods and Counselling at HC and community level.	Yes	CCs, VHV/CHEs and TBAs have established contact and provided education on the importance of BS and counseled WRA to go to the HC.
Increase from 18% to 60% mothers with children less than 24 months old who know three modern methods of birth spacing.	Yes	CCs, VHV/CHEs and TBAs are all part of a comprehensive program of educating WRA about BS. A complimentary BS program as well as the mother's clubs at CFV also improves knowledge.
Increase from 32% to 50% mothers with children less than 24 months old who desire no children in the next two years or do not know who use a modern contraceptive method.	Yes	CCs, VHV/CHEs and TBAs are all part of a comprehensive program of educating WRA about BS. A complimentary BS program as well as the mother's clubs at CFV also improves knowledge.
Increase from 25% to 35% mothers with children less than 24 months old who initiated use of modern method of birth spacing within the first three months following pregnancy.	Yes	CCs, VHV/CHEs and TBAs are all part of a comprehensive program of educating WRA about BS. A complimentary BS program as well as the mother's clubs at CFV also improves knowledge.
Increase from 29% to 50% children <24 months whose next sibling is two or more years older.	Yes	Increased 4.4 % as shown in August 2003 to April 2004 LQAS report.
Nutrition		
Increase from 13% to 33% the number of mothers who initiate breastfeeding within the first hour after delivery.	Yes	CCs and VHV/CHEs provide education to pregnant women before delivery. MWs and TBAs give them education during delivery the importance of colostrum. A World Breastfeeding Week campaign was conducted in 5 different parts of 5 HC catchment areas (following training by Helen Keller (HKI) and MOH also promoted breastfeeding awareness by advertising on radio and TV.
Increase from 19% to 25% mothers who breastfeed exclusively up to 6 months after delivery.	No	The factors affecting this indicator relate to poverty. Women, who must also be breadwinners, are often found in markets, as sellers, or out in the rice fields as laborers etc. These women leave their babies at home with their grandmothers or older sisters. Observation also shows that mothers sometimes add some water after

		breastfeeding because they think that breast milk is sweet. These are challenges for the project, the changes may be slow but the staff will continue applying BCC strategy. New formative research will shed some new ideas in for behavior change.
Increase from 12% to 32% mothers of children <2 who received increased fluids and continued feeding during an illness in the past two weeks.	Yes	Project officers trained CC, TBAs and VHV/CHEs in cooperation with OD and HC staff. The HCs have provided more education to villagers during immunization outreach. Mothers also receive knowledge through Hearth sessions and mothers clubs.
Decrease from 42% to 32%, children <2 years of age who are underweight (-2 SD from the median wfa).	Yes	The final phase of the NERP program in the Phase I area shows a decrease from 41% to 32% of total malnourished children, who enrolled in the Hearth program.
Increase from 33% to 50% of mothers with children less than 24 months old who report having received IFT supplements.	Yes	HCs give iron to pregnant women during prenatal check-ups. Lactating mothers get their iron during the monthly immunization visits by the HC staff.
Increase from 35% to 60% children 6-23 months of age who received at least one vitamin A capsule in the last 6 mos.	Yes	The national Vitamin A campaign is conducted every six months (twice a year). The project works with the MoH to support this campaign.
Increase from 17% to 30% women who receive a VAC within 8 weeks postpartum.	Yes	HC staff provide Vitamin A capsules to lactating mothers during immunization outreach. HC staff go to homes if the mothers are unable to attend the outreach.
Increase from 14% to 20% number of households with children less than 24 months who receive basic home gardening instruction/training.	Yes	More than 1,552 families have received training in home gardening, fish raising, treadle pump and ring well installation in 32 villages of BSOD in 2003-04.
Immunization		
Increase from 28% to 60% children under 2 who have complete immunization coverage.	Yes	HC staff conducted immunization outreach in cooperation with CCs and VHV/CHE every month. Education was provided by volunteers, HC staff and national radio and TV.
Increase from 9% to 40% mothers with children less than 24 months who have at least two TT vaccinations before the birth of their youngest child.	Yes	HC staff conducted immunization outreach in cooperation with CCs and VHV/CHE every month. Education was provided by volunteers, HC staff and national radio and TV.
Capacity Building		
Standardized technical backstopping protocol includes standards for identification of innovative approaches and best practices that can be applied in other ADRA programs.	No	ADRA International is in the process of curriculum development and setting of standards for the entire health portfolio. This is being done incrementally and is slated to be completed by summer 2006. ADRA International program management bureau began and in-depth redesign of backstopping protocol in September 2004.
Lessons learned/innovative approaches from CSXVII are published internally.	Yes	Reports prepared are shared with other ADRA health projects upon request, when the backstop officer identifies a learning opportunity and/or at conferences.
Lessons learned/innovative approaches from CSXVII are published /presented in	Yes	Two abstracts have been written for a National Conference and for the Global

at least two publications/forums external to ADRA.		Health Conference. A presentation was made at ADRA International's Health Summit in January 2004. Considerable information and ideas have been exchanged by the CS project with other CS projects within Cambodia, mainly through the Combined CS Quarterly Meetings
Documented lessons learned/best practices from CSXVII are applied to other ADRA health programs.	Yes	Cross visits with ADRA Cambodia Pursat USAID funded MCH project share LQAS, Training materials, etc. The work with HCMCs is being shared with ADRA's Integrated Rural Development programs and their work with other community based organizations. Globally, ADRA Cambodia's Child Friendly Village model is being shared.
LQAS system in place and functioning.	Yes	See Appendix 1.
Sustainability		
Each Health Center has a customized fee for service schedule established by the respective Health Center Management Committee.	Yes	All the HCs have customized fees for services assisted by The HC coordinator.
Each Health Center in the project area has a posted fee schedule.	Yes	The fee schedule boards are posted in the ten HCs in the project area with assistance by the HC coordinator.
The BSOD Health Department and Health Centers train and supervise village health volunteers (Village Health Support Group), and traditional birth attendants in methods of community education for health behavior change, within MOH policy.	Yes	This is a new sustainability objective. The CSP will catch up this during Phase II up to EOP.
The BSOD Health Department and health centers train village health teams to implement selected interventions, such as Hearth Nutritional Rehabilitation, Safe Motherhood, and Child Spacing.	Yes	This is a new sustainability objective. The CSP will catch up this during Phase II up to EOP.
Each Health Center has a management committee that carries out functions and participates in decision-making.	Yes	The HC coordinator and MEAO assisted in setting up or revitalizing the HCMCs established by OD and provided the training to their needs in cooperation with OD to fit the national policy. The HC coordinator attends meetings with HCMCs every two months in order to gradually improve the HCMC to be longer running committee.
Health Center Management and/or Child Friendly Village Committees have community health strategic plans that include: 3.2.1. Motivation of village health volunteers and traditional birth attendants. 3.2.2. Community health events, such as immunization days, growth monitoring/promotion, Hearth Nutritional Rehabilitation programs, community health fairs, etc... 3.2.3. Periodic review of	Yes	This plan was developed during the sustainability focused mid-term evaluation and will be taking place during the last 2 years of the project.

community health data for the purpose of community health planning.
3.2.4. Advocacy with the health department and other stakeholders for community health needs.

A major step in the phase-out plan was begun during the mid-term evaluation when all the community partners designed the sustainability objectives included above. The CSP has begun working with HC Managers towards developing Community Health Strategic Plans. The conducting of Community Training is being slowly shifted to the OD and HC. CFVC, HCMC are beginning to take responsibility of planning and conducting village health days and other community health promotion activities. TBA, VHV/CHEs, CC are in the process of integration with the existing HC structures. There are challenges in this plan, considering 516 volunteers currently and the target number of volunteers per the MOH plan is only two per village. The CSP expects that during the consolidation phase (last phase of CS project), OD, HC and community structure will have taken ownership of the project. The MOH has requested that ADRA work in another district of the Kampong Thom Province where there is no current health NGO and ADRA is currently planning to submit a costed extension supporting work in that area.

II CONSTRAINTS and ACTION TAKEN TO ADDRESS THEM

a Child Friendly Village (CFV)

The Phase I target area has 10 CFVCs but none of the villages had yet reached the preset criteria of a Child Friendly Village (CFV). Staff has discussed this problem with MOH staff and no constraining factors are clear. It appears that not all Child Friendly Village Committee (CFVC) members understand the concept of the work needed to gain recognition as being a CFV, the CFVCs' have not yet developed working plans, and CFVCs appear to focus their activities on the Hearth program and NERP only.

At a special monthly staff meeting attended by staff and CCs, a review was made of the CFV initiative and discussion took place on actions needed to address its problems. The results of this meeting were agreements by all to the following: 1. A working plan will be produced at the end of each community training. 2. Refreshing training for CFVC will be conducted on the idea of competition and CFV indicators, and 3. A review of CFV indicators was made.(see revised CFV indicators, appendices 10 p. 64).

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b Hearth Program

One lesson learned from Phase I was that Hearth Program implemented in the 10 CFVC areas of five old HC catchment areas were modified. As was understood by ADRA staff during the training at PFDs Hearth program, with the contributions and the participation from the community covering the rice porridge and some vegetables, most meat that was added was being subsidized. This was reviewed during the MTE and since then project leaders and staff have reviewed the Hearth strategies, including PDI, and NERP. The current supporting project, with research funded by GTZ, does not include any subsidized food, only what the community contributes.

c Increase demand in Birth Spacing Methods

Nearing the end of Phase I, project leadership identified a gap in the project Birth Spacing component when project activities would shift to Phase II Health Center Catchment areas. The Community Birthspacing Distribution Resource Network is a supporting project that has VHVs currently educating mothers and promoting birth spacing methods and services available mainly at the local health center. It was determined that a significant factor influencing utilization was related to the convenience of accessing counseling and supplies. Therefore the project team has established a network of Community Based Distributors (CBDs) to fill the increased demand for family planning information and supplies (particularly COC/POP pills and Condoms) especially targeting women in the village areas that are more distant from health centers and population centers where other private services are available.

III TECHNICAL ASSISTANCE

Documenting Research

In this next year focus will be on documenting research done, doing additional research such as the comparison of Village volunteers noted in Appendix 5, and documenting lessons learned. A recent MPH graduate with previous NGO work in Nigeria has joined the team, as planned in the budget, and will work on this with the Project Advisor. As well, the Associate Director who is doing graduate work in International Development with a concentration in public health will join in some research.

Automation of Data collection, monitoring and reporting

To maximize computer utilization and increasing staff efficiency, the IT technical assistant is working with the Project Advisor to design a computer database system to automate the Project Progress Monitoring System. As well, ADRA Cambodia is trialing a system already developed in Australia called AID-IT which already does this working from the log frame. The final version is recently completed and hopefully soon will be ready for us in all ADRA Cambodia's programs. The ADRA Asia RH technical advisor will be available to help review and advise on this process.

IV PROGRAM CHANGES

New Project Advisor

Dr. Leonard Uisetiawan joined the CSP leadership team as Project Advisor in January 2004 after approval from USAID replacing Geof Bowman who transferred to World Relief in May 2003. Leonard brings with him various experiences from Indonesia and has succeeded in assisting the CSP smoothly transition from Phase I into Phase II, reviewing and building on lessons learned in the process.

Revision of indicators

Project Indicators were reviewed on July 2004 by the project management team, ADRA International TA, ADRA Cambodia Associate Director and the MTE consultant. Twelve indicators were found differently either in baseline survey, in LQAS and in DIP. Revision was made and sent to USAID for approval along with the Mid-term Evaluation. (See appendix 7 p. 52)

Village Health Volunteer Strategy

As documented in the 2nd Annual Report, in the CSP Phase I a change has taken place in the volunteer structure from Phase I to Phase II. While in Phase I Commune Coordinators (CC) were chosen to direct and monitor Village Health Volunteers (VHV) in each of the five HC catchment

areas, in Phase II it was decided not to use Commune Coordinator on the second phase, and only village health volunteers under new name of Community Health Educator (CHE).

Unlike the VHVs, the CHEs will have required monthly output (report); required monthly home visits (minimal 50% of house number assigned) and their work will be monitored directly by Community Leader and/or family in the community. Although the original plan, as presented in the 2nd Annual Report, was to pay the new CHE only for some special programs, like the hearth program as this program requires full time work over an extended period of time, CSP leadership and staff understand that paying only some CHEs and not others would create jealousy and reduce efficiency in the effectiveness in Phase II. Therefore the project is proposing to pay all new CHEs a small transportation allowance in the new project through savings of not needing to pay CCs in Phase II as well as savings in vehicle operation. A comparative study is planned to compare the effectiveness of phase one VHV and Phase II CHE. (See appendix 6 p.50)

Complementary/Matching Projects

The Planned match from the AusAID funded Home Gardening project benefited the project as expected, however, the project and funding was for one year less than anticipated. The following projects have been (or are now) submitted as replacement match projects as they all contribute to the objectives of the project:

Community Birthspacing Distributor Resources Network (CBDRN)

ADRA had received a total of $10,375 for a 12 month project support in establishing community birthspacing distributors' networks in five HC catchment's area of Phase I project site. Two full time nurse-midwives as Birth Spacing Officers had been added to CS workforce, where they do training, follow-up, evaluation, oversee the birth spacing methods supplies, community campaign and local radio promotion. This project works out of the Child Survival office in Kampong Thom and the CS project manager and advisor supervise the activities.

Hearth Nutrition Program (HNP)

ADRA Cambodia received $10,160 from GTZ for piloting a Nutrition project based on Hearth approached. This pilot program will cover five villages of the BSOD of the Kampong Thom province to thoroughly test a community based nutrition model that can be replicated throughout the Kampong Thom Province and Cambodia as a whole. The intention is further to intensively monitor and evaluate the process and outcome of the pilot and to document and disseminate the results/lessons learnt in order to make the experiences accessible to a wide range of stakeholders at national level.

Home Gardening Nutrition Support Program (HGNS)

Help International has provided ADRA Cambodia with $5,000 as a matching project supporting home gardening activities in 10 Child Friendly Villages of Phase II's five Health Center Catchment areas. The objective of home gardening program is to provide agriculture and nutrition training along with incentives such as seeds to encourage families to grow home gardens that can supply the family nutritional need and as source of income generation. It is expected that this program will complement the efforts of CFVC in meeting the nutrition requirement of its village.

Baray Santuk Sanitation and Water Resource Project (BSSWR)

This is a matching project from ADRA Australia and community contributions with the budget of $61,950. The objective of the project is to enable the people of Baray and Santuk Districts to access improved appropriate sanitation facilities, rain water collection devices, and subsurface water

resources. This project is complementing health & sanitation education by Village Health Volunteers and provision of water resources to support the HGNS program.

Women's Empowerment through Literacy Project (WETL)
ADRA Cambodia had received $11,000 support from North American Division Ingathering for this project. The project goal is to empower women and families enabling them to support their families by empowerment and literacy skills gained thru informal learning within the context of their environment. This project will use the Reflect method to form community women's groups to address community concerns including emphasis on health issues, and will act as complementary program to CS community health education.

V PROJECT MONITORING and EVALUATION SYSTEM

As mentioned above the CSP leadership developed new simplified forms of data collection with an information flow from the TBA/VHV/CHE up to the CC, CS staff, CS leadership and country administration and set up a monitoring system that provides observational data, either from the HCs or from staff observation, that confirms and complements the reported health practices in the LQAS surveys.

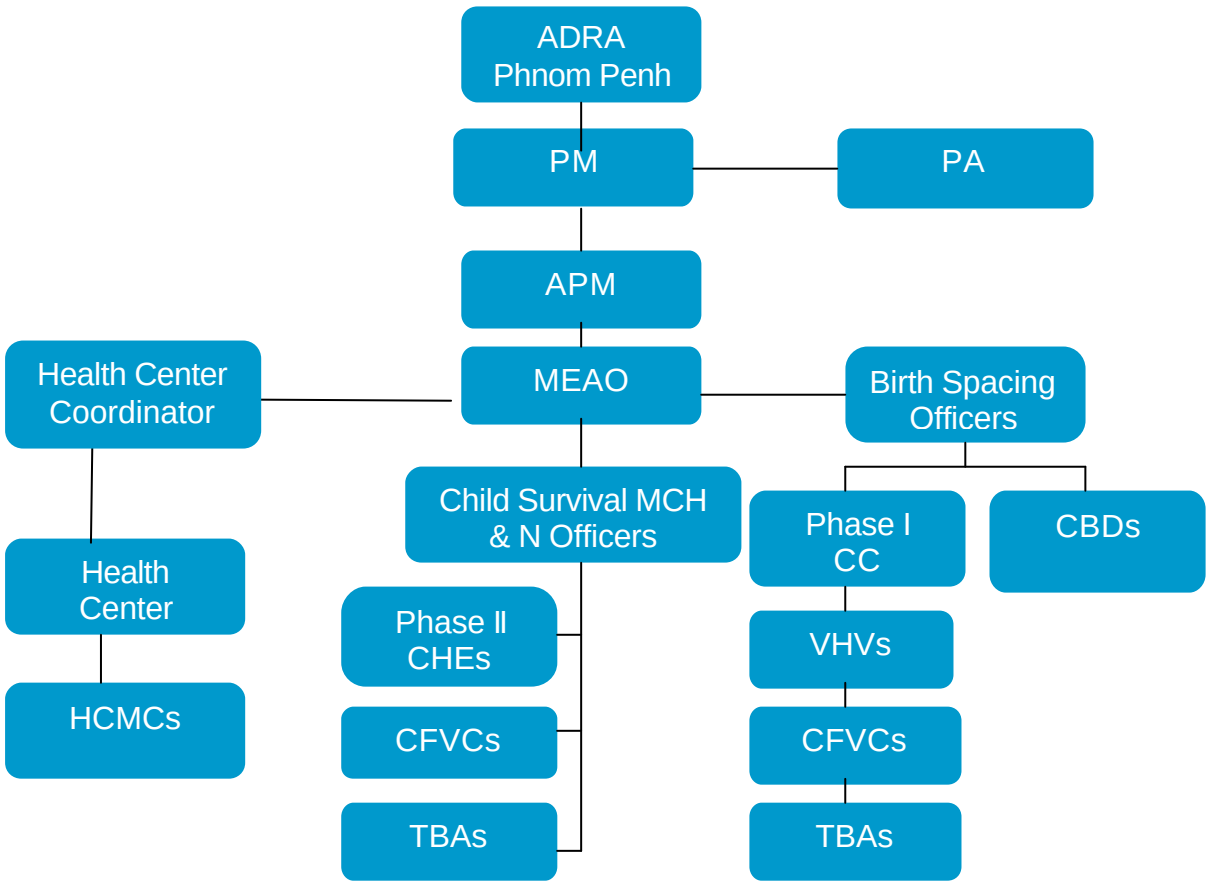
The Project Progress Monitoring provides streamlined data from community and captures most significant data to feed the process indicators and adjustment is done accordingly to meet the indicators need. It is divided into three levels of data collection, first at the community, second with the staff level and third at the project management level. Community level data collection happens every day/activities, staff level data collection is done every week/activity while project management level is collected every month. The actual time involved for staff in the new system capered with the previous system is about the same as the forms were streamlined and similar data was collected and processed earlier.

The monitoring forms for data collection were revised from previous forms according to the experiences of project staff. Not all the project indicators were being collected in previous forms and it was found that there was some overlap. Although much documentation was collected, only a small portion of the data was streamlined into reports for monitoring and analysis. The revised monitoring forms will reduce the work of volunteers enabling them to concentrate their efforts in improving community health in the area required by project indicators. The data to be collected weekly and compared with project's indicators is streamlined to provide the same or less effort as in the past and assists in identifying any low indicators each month so that intervention strategies can be developed to address them. The information collection at the community is through TBAs, VHV/CHEs, CCs, and CBDs, which goes to the project staff level that will summarize all data from those community volunteers into the monthly report at the end of each month. The first draft of the monitoring forms was prepared in June 2004.

Type of monitoring forms

Community weekly report forms	Project staff monthly report forms
TBA report	Nutrition and MCH Officers reports
CHE/VHV report	BS Officer reports
CBD report	HC coordinator report
Most Significant Change Reports (MSC)	

Project Reporting Flowchart



Reporting flow

During every field visit, staffs will observe and listen, sensitive to any changes or significant stories from community. They will enter this information into the Most Significant Change (MSC) reports, which then will be submitted monthly to MEAO. (See p.31 and 62 for further description of MSC.)

Community Birth Spacing Resources

1. The community based distributors (CBDs) are to register their clients every day in the daily records.
2. At the end of each month the CBDs summarize the data from the daily record into the monthly record sheet, then give one to the Birth Spacing Officer (BSO) and another to relevant HC in order to obtain new BS supplies for the next month.
3. The BSOs summarize all the data from CBDs monthly record sheet into a CBDRN project monthly report which is given to the Project MEAO, APM, PM/PA etc..

Nutrition/MCH Officers

Phase I Area (phased out)

1. The VHVs and TBAs fill the activities and any feedback received into daily activity forms describing what they did and at the end of the month these are given to CCs through the VHV chief.

2. The CCs summarize all VHV & TBA monthly reports into a monthly report form that is given to the Child Survival (Nutrition and MCH) Officers.
3. Child Survival Officers summarize and consolidate data preparing a monthly report that is given to the MEAO.

Phase II (new phase)

1. The CHEs and TBAs enter the activities and any feedback received in their monthly report, that are given to the Child Survival Officers through the CHE chief.
2. The Child Survival summarize and consolidate data preparing a monthly report that is given to the MEAO.

Health center coordinator

1. Each HC completes the desk data in the monthly standard report at the end of the month that is then given to the HC coordinator.
2. The HC Coordinator summarizes all the reports from the ten HCs into his monthly report that he submits to the MEAO.

Mid Term Evaluation Conclusion and Recommendation

Conclusion	**Recommendation**
The project is on track to reach health and health behavior indicators in all four implementation strategies.	Keep up the good work!
It is doubtful that the BSOD Health Department will have sufficient resources to continue the Hearth Nutritional Rehabilitation Intervention, as it is done in the project.	Training of Trainers to BSOD Health Department to enable them to train and supervise health center staff and community level providers in growth monitoring/promotion and community level nutrition health education activities, rather than attempt to make the full Hearth program sustainable.
To be effective as a tool for nutrition education and feeding behavior change, Hearth must be done according to protocol.	Even though it will be a difficult transition, strive to discontinue the practice of providing food supplements to Hearth participants. However, you must use good judgment as it is always hard to take away a benefit once provided. Food supplementation is not sustainable.
Obstetric skills of midwives should be assessed.	Develop a check list assessment tool to be used by health center chiefs and project supervisors in assessing skill manifest in recent deliveries.
A constraint to accessibility to good obstetric care is understaffing of health centers.	Advocate, with government entities responsible for health center budgets, for staffing in accordance with MOH policy.
There are a number of superstitions about pregnancy, childbirth, and child spacing that inhibit quality care.	Participatory qualitative research may shed light on ways of countering such superstitions.
Team efforts of health center staff and community level health providers are commendable.	Continue to foster team efforts in community health events and education for health behavior change.
Community-based emergency obstetric referral and systems are sorely needed.	Plan with community committees and the health department for establishment of emergency obstetric referral systems. Include emergency transport.

The extant of need for expansion of birth spacing clinical services or change in the method mix is not readily apparent.	Give study to the need for, and feasibility of, such changes.
Orientation sessions for religious leaders, who then disseminate immunization messages, should be inexpensive and effective.	Consider doing it.
The MOH pilot program of monitory incentives for full immunization of children is interesting.	Monitor effectiveness and watch for constraints.
There is doubt about reliability of the cold chain.	In other CS projects monitoring of the cold chain alone has resulted in improvement.
LQAS data is not only useful for project management decisions, but is of value for community level committees.	Share graphic representation of LQAS data with community committees. Thus they may be enabled to make decisions about health needs in the community without regard to their level of literacy.
A test of the volunteer spirit will come at end of project when the officially recognized number of volunteers will have to be reduced in order to comply with government policy	Encourage community committees to take responsibility for non-financial incentives for volunteers.
The Child Friendly Village initiative is inexpensive and effective.	Urge the BSOD Health Department and/or the Ministry of Rural Development to assume responsibility for sustaining the Child Friendly Village program. Provide whatever training is necessary.
The project is to be commended for excellent community health education activities.	Continue training and mentoring community and health center level providers in education for health behavior change.
There are a number of good ideas in the DIP that project partners, particularly at the health center and health department levels, are not fully aware of.	Translate the entire DIP into Khmer and share it with project partners.
The Revised Sustainability Objectives are really good!	The hard part is to make it happen! Make sustainability the main emphasis of the remainder of the project. Challenge the ADRA International Health Team for support in this.
The proposed changes in management of community volunteer activities are promising, but there are some cautions to be made.	Be careful in interpreting LQAS differences. Phase one has a longer track record and more experience. Be careful that per diems do not change motivation of the volunteers from altruism to financial gain.
There are discrepancies in wording between some indicators in the DIP as compared to the Baseline Survey.	Make corrections in indicators in the DIP Program Goals and Objectives log-frame to make it consistent with the Baseline Survey.
ADRA Cambodia has more than usual country office capacity for	You are to be commended!

technical and managerial support.	

To implement these recommendations, project staff has developed a working plan with objectives from the log frame with specific actions addressing each of these recommendations.

Action and Work Plan

		Activities		persons
To enable HC to train and supervise community level providers in growth monitoring/promotion	80% HC training and supervising community level providers	- Training of Trainers for Health center partners on GM and promotion. - Refresher and/or follow-up	-2nd week of December 2004 Refresher after 9 months -HC monthly meeting	-APM, NO -HCC officer
To increase effectiveness of HEARTH	All Child Friendly Villages in Phase II participating in the Hearth program are following Hearth protocol.	-Retraining or refresher of staff on Hearth protocol	-July 7, 2004 - Refresher for all staff after 1 month -Refresher after 9 months	- APM - PA
Obstetric skills of midwives should be assessed.	-All midwives in 10 HCs will be assessed on obstetric skills - Refresher training planned by OD	-Develop/adapt a check list assessment tool to be used by health center chiefs and project supervisors in assessing skill manifest in recent deliveries. -Advocacy and Facilitation by in regard to the training need.	9 months basis after initial training starting -Joint Supervisory visit (OD,HC and ADRA) . Every 6 months after initial training. (Dec. 2004, and July 2005) -as necessary	MAEO, HC Coordinator and OD supervisor -OD and HC staff
To increase number of qualified health center staff.	-5 HC in project phase 2 area will experience improved staffing and budget management (this is a hope, but will depend on the MOH, see comment below)	Advocate, with MOH for staffing and budgeting in accordance with MOH policy.	Bimonthly Prococom meeting, and monthly OD meeting	MAEO, HC Coordinator,APM, PM
To reduce the number of superstitions among mothers, concerning pregnancy, childbirth, and child spacing.	60% of mothers respond correctly to healthy and harmful behaviour practices during pregnancy, childbirth and child spacing.	Participatory qualitative research will take place to identify superstitions and their roots	Monthly mother's club meetings will be used to discuss with mothers about superstitions	Field team, CCs, HCMW, And peer mothers
To foster collaboration with HC, CS team and Existing community Volunteers for IEC and BCC community events	50% of villages in second phase of HC catchment areas conducting BCC and IEC once a month.	Community Integrated Health day	monthly basis beginning August 2004	CC, VHV/CHE, TBA, Health Center Staff, Peer mothers club, CVF members, CS staffs
To improve access of women to emergency obstetric care	All villages in the 10 HCs of BSOD have community-based emergency obstetric referral systems established and functioning	Plan with community committees and the health department for establishment of emergency obstetric referral systems. Include emergency transport, and importance of addressing the three delays.	In the next CFCC&CRFC quarterly meeting will have a draft of agreement for Moto-ambulance for 10 HC partners	BSOD, 10HCs,CRFC, CS team
To establish a network of Community Based Distributors (CBDs) to fill the increased demand for family planning information and supplies.	Increase from 33% to 60% of women in target area accessing and utilizing birth spacing services	– Recruit and train CBD in establishment of sustainable linkages and supply lines for BS supplies with the MOH system.	May,2004 until EOP	PA,PM,APM, BSO and new CBDs
To increase dissemination of Health messages thru religious leaders	* 50% Cambodian traditional religious ceremonies will include	– Establish good relationship with pagodas and	July, 2004 until EOP	CS, CC, HCMC,VHV Chief, BSO

VI PROGRAMS MANAGEMENT SYSTEM

Financial management systems

To ensure that the program runs smoothly, ADRA has established a multi-level financial management system. These levels include the project onsite team (PROJECT), the in-country support team (ADMIN), and the US based support team (HQ). The core elements include authorization of transactions, recording of transactions, production of reports, and review of those reports for accuracy, reasonableness, and comparison to budget and project scope. The authorization of transactions is done mainly at the PROJECT level, with administration support expenses incurred by the ADMIN and HQ support teams authorized at their respective levels. The recording of transactions is started at the PROJECT level which operates a petty cash system; however, review and monthly reports are done in ADMIN.

Factors that have made a positive impact on financial management include on-going staff capacity building in financial management at the PROJECT and ADMIN level through continued education and mentoring. The PROJECT follows the ADRA Cambodia Policies which include segregation of duties at the PROJECT and ADMIN level and includes a Project Management Committee (PMC). The PMC is composed of the Project Manager (PM), Project Advisor (PA), Assistant Project Manager (APM - formerly Activity Coordinator), MEA Officer and Administrative Assistant; and must authorize all major project transactions up to $1,000. The PM or PA can authorize expenditure or purchases up to $500, the PMC up to $1000, Country or Associate Director up to $3,000, ADCOM up to $10,000, above which the ADRA Country Board approves items. A cash flow projection chart is maintained at PROJECT level to help senior project staff when requesting cash from ADMIN and when preparing the bi-monthly drawdowns from USAID and other project donors. This is also used as a tool to monitor expenditure against budget.

The project maintains five bank accounts to be able to operate the project smoothly. The first (1) located at the bank closest to the project site, is used for petty cash replenishment, payroll, and specific larger field check payments. Signatories include the PM, PA, Administrative Assistant, ADMIN Chief Accountant (as an alternate) and all checks must be countersigned. Project petty cash is limited to $6,000 total with up to $500 of this in cash held in the project safe. The second, third, and fourth accounts are for holding incoming funds, paying out project costs in Phnom Penh, and transfers to the field petty cash account. These checking (2) and saving (1) accounts in Phnom Penh have the following signatories; Country Director, Associate Country Director, Finance Director, Gov./HR Department Director, and a Board Representative – all checks must be countersigned. The Associate Country Director and Finance Director are the normal signatories. The fifth account (5) is an account in Washington D.C. for receipt of project funds from USAID and transfers to Cambodia as well as payment of any US-based expenses. The majority of funds from this account are immediately transferred into the project account (#3) upon receipt. All bank accounts are maintained in US Dollars.

Roles and Responsibilities Ensuring Accountability

Monthly financial statements are sent to the ADRA HQ office. There the Financial Analyst analyzes them and refers potential problems to the Senior Finance Administrator. This helps to avoid misuse of funds and aids in tracking project activities. Regular direct communication between the HQ Finance administrator, CD, AD, FD, PM, and PA is easily performed through emailing and follow-up.

Both SF-269 and 272 reports are prepared quarterly by the HQ grant accountant and posted on line. In addition hard copies SF-269 are SF-272 sent to the project Cognizant Technical Officer (CTO) at USAID Washington and Dept of Health and Human Services, respectively.

ADRA Cambodia participates in the overall institutional audit of ADRA International. The scope (range) of the A-133 audit includes all centrally funded Federal projects and is conducted annually by the accounting firm of Price Waterhouse Coopers (PWC). Audits of implementing offices are scheduled based on availability of audit providers and other logistic considerations. Any material findings associated with the implementation of projects in Cambodia are reflected in the overall audit report provided by PWC to ADRA International. In that report the implementing field office associated with each finding is specifically identified. ADRA International works with those field offices and donor agencies to resolve all findings. Audit findings from previous audits have been addressed and resolved, and at present there are no outstanding issues from those findings.

US government regulations training

The ADRA Finance Director attended a Jt PVO US government regulation workshop hosted by CRS in May 2004 in Sri Lanka. Following this the Finance Director co-led (with the Associate Director, a CPA who used to facilitate in such workshops) an in-country workshop with the same materials. All CSP leadership attended as well as the administration officer. The Finance Director and Associate Director not only provided this training but also provide on-going financial and administrative technical assistance to the project.

Human Resources

The project follows the Human Resources Management System (HRMS) set up by ADRA Cambodia HR policy and facilitated by the Human Resources Department Director (HRD) and Country & Associate Country Directors. HR documents such as job contracts, position profiles, personnel health information, etc. are prepared by the PM and HRD with approval from the PMC, PA, AD and ADCOM as per policy.

ADRA Cambodia has an unusually generous continuing education policy for all project staff members. For approved courses, ADRA Cambodia will pay 90% of training cost, up to $750 per year as funds are available. There are multiple training opportunities in Phnom Penh. The staff has never had trouble finding continuing education resources. Usually they attend courses on their own time.

Supervision

At field level, supervision starts with visits from the AD. These visits focus on programmatic, administrative, and financial areas, as well as monitoring the implementation of ADRA Cambodia policies. The AD schedules to visit the project once a month, providing advise to senior project staff as well to the CS team members. PM, APM and MEAO observe/supervise field staff at work two or three times a week (some times more often than this). The PA also visits the team members in the field as often as possible. The PA stays on site and continuously monitors project implementation, use of finances and staff performance. Field visits are made weekly, more frequently when training is in process. The PM continuously oversees the technical implementation of the project, and is often found in the field, especially encouraging and mentoring weaker team members. The APM assists the PM in over seeing the technical implementation of the project, making frequent field visits when training is in progress and the MEAO makes regular field visits to monitor correct use of data collection forms. The CBDRN staff oversees the activities of the CCs who support the VHVs in

Phase I. In the Phase II HC catchment areas the CS Officers monitor the new CHE chiefs who directly supervise CHEs. Each project team makes up a weekly plan, as well as writing on the office board their daily movements when out of the office. Through these mechanisms, and the project radios all staff carry in the field, the whereabouts of each team member is known at all times. For security purposes the on-duty guard keeps in radio contact with team members who arrive after working hours.

At the ADRA International level, the Reproductive Health Advisor, Debbie Herold, provides technical backstopping of this project along with Satish Pandey in the ADRA Asia regional office. Debbie visited the project after the MTE and is in regular e-mail contact with the project leadership and the country administration. Debbie's visit was during July 2004 while the project needed more technical assistance on the review of the current Hearth program learned from the PFD pilot as well as on M&E.

Staff turnover

Project staff turn-over

The most significant staff turnover was the arrival of the new PA mentioned above. As well as providing support for existing program plans and mentoring the CS team, he has brought new innovative ideas. There have been no significant factors that have impeded the progress of the project. Among 18 CS employees, there were four CS team members (2 females and 2 males) who have resigned. One training coordinator, one MCH Officer and two Nutrition Officers resigned for personal reasons, ending of work suspension agreement with the government, newly wed and wanting to stay with family in Phnom Penh and continuing study at Phnom Penh. The CSP PMC has been able to recruit replacements allowing sufficient overlap and training while retaining a strong team spirit.

Lines of Command developed

The CSXVII project HR lines of command are set up according to the CSP organization chart. During 2004, the Project Manager is spending more time with advocacy on the new CS national planning, the Activity Coordinator changed some responsibilities and is now called the Assistant Project manager and the M&E Officer also was given more responsibilities and is now called the Monitoring, Evaluation, & Activities Officer. (Appendices 2, p. 38)

Communication System and Team Development

CSP leadership staff each carries project mobile phones while most project staff also have phones which now work in some of the project area. The project also provides all staff with held radios, which they keep with them at all times in the field. This gives them access to the base station at the CS office, other CS staff and also the BSOD/Referral Hospital/HC radio network. The network not only increases field efficiency but also acts as a security backup, should a breakdown, accident or incident occur.

Team Development

The project has taken a synergistic team-based approach since its inception-from an open approach to staff employment to the participatory system used in team meetings and in relating to the community. Staff are encouraged to give their ideas and opinions, as well as given permission to make mistakes, and then learn from those experiences. This is encouraged through staff meetings that are held at least once per month, sometimes twice if needed. During the recent selection process for a new Project Advisor, staff was able to join in the interviewing process.

Throughout the life of the project to date, time has been invested in team building and in-group activities. The CCs have also been included, due to their intimate knowledge of village life and behaviors and also to reinforce their integration into the CS team. In the transition period from Phase I to Phase II, Project Management team had conducted a consolidation team meeting to reinforced teamwork among the project staff, CCs and HC & OD staff. Since then the CCs have also participated in the meeting and shared their opinions/experiences to the team in terms of running the activities smoothly and successfully.

The project not only focuses on staff and CCs in team building, but also works to ensure that other volunteers, such as TBAs and VHV/CHE's are part of the team. A TBAs follow up meeting is held every month at each of the ten HCs. Along with the checklists for TBA reports and kits during the meeting, lessons learned are discussed and feedback given. A similar meeting is held monthly with each VHV/CHE chief and the last one is the quarterly meeting with all the VHV/CHE members to insure the project health intervention and community participation remain the keys for community's health need.

The Child Survival Coordinating Committee (CSCC) and Community Representative Feedback Committee (CRFC) meet every two months with the main aim to strengthen the relationships between the project and the local MoH partners to maximize cooperation and synergy. During the meeting the group discusses on the coordination of project activities and deal with any issues raised by any of the meeting participants (Debbie Herold and Alan Fletcher (technical backstop from the NZ match training portion of the project) joined this meeting as well).

The core values of ADRA Cambodia, compassion, integrity and respect, are frequently discussed when making decisions, and in team meetings as the team try to reflect these values in their work, both in the office and in the field. There have been many instances of the team demonstrating compassion, when in the field, as well as demonstrating integrity when dealing with money and respect when dealing with each other and the community. Also, in response to appeals form the PM ADRA employees from other projects also provided support to a village leader who was very sick and to one active CC who had kidney stones, etc…).

PVO assessment by the local partner

During the MTE, one week was devoted to gathering of qualitative information about PVO performance through Focus Group Discussions. The CSP Team conducted 35 Focus Group Discussions in randomly chosen villages with the MTE evaluation team attending many of these. Fifteen groups were made up of mothers of children less than two years of age, ten groups were Village Health Volunteers, five were Traditional Birth Attendants, and five were members of Health Center Management or Child Friendly Village Committees. Six questions were used as the basis for discussion and are presented here with summaries of the responses:

1. What value are project activities to you and your child (ren)?
   Improved health and changed health behaviors were prominent in values identified by all groups. VHVs and TBAs spoke of various incentives, including training, income from increased utilization of TBA services, recognition by communities, and per diems.
2. What have you learned from the project?
   Disease prevention and health promoting behavior changes related to all four project implementation strategies were spoken of as highly valued.
3. What do you do differently for your health and the health of your child because of the project?

Interesting changes in behavior learned from these discussions, include mothers no longer pre chewing baby's food, reduction in the practice of 'roasting' (prolonged exposure to heat of mother after delivery), no longer spiting chewed betel leaves on sick persons, not applying wasp nests to cut umbilical cords, as well as increased utilization of the HC and other more conventional improved health behaviors.

4. Has health care in your community changed because of the project? If so, in what way?
   Answers were similar to those of the previous questions, with more emphasis on improved immunization, breast feeding and infant feeding, as well as increased utilization of health centers.
5. How can the project be improved?
   The most frequent recommendation was for more training. An unsustainable suggestion is food distribution.
6. How can the benefits and activities of the project be made sustainable?
   Team efforts of village level committees, volunteer providers and HC staff members. Training again emphasized. An interesting comment made by a mother is "must memorize and practice what we have learned".

PVO in country coordination/collaboration

CS Projects Coordination Workshop

As ADRA Cambodia was due to host the routine quarterly meeting of USAID CS grantees, it instead took the initiative to upgrade this meeting into a workshop for NGOs active in CS after the high level visit of the global CS partnership in Cambodia. This workshop preparation now has taken new vision and form to embrace all interested NGOs working with CS/MCH in Cambodia and is now under MEDiCAM[1] coordination with ADRA leading and participating in the various planning committees. This "Partner CS workshop" will be conducted in December 2004.

Follow on the High Level Consultation visit of Global Child Survival Partnership

The purpose of 'Partner CS workshop' is to lay the foundation leading to formation of in-country Child Survival NGO partnership. ADRA works closely as co facilitator of MEDiCAM in this movement. The goal of this meeting is to discuss more on the issues of meeting the MDG #4 Goal relating to the of under five mortality rate which is still high (Cambodia is #2 among developing countries). The participants will identify the best practices, cross cutting issues, and common indicators. This will follow-on the MOH National Conference on Child Survival held in October whose aim is to define the Cambodia CSP partnership and set the way forward toward a common plan of action for CS.

Provincial Nutrition Coordinating Committee (PNCC) Monthly Meeting

ADRA CSP is one among other NGOs active in the nutrition program intervention in Kampong Thom province. After a Provincial Nutrition Coordinating Committee (PNCC) was established by the government and coordinated with financial support by GTZ (German government), ADRA CSP had joined and presented Nutrition/Hearth Program to the PNCC participants. After seeing preliminary results of the CSP Hearth program, the GTZ/Food Security and Nutrition Policy Support Project (FSNPSP) was interested and funded the HNP listed above for a small pilot area (5 villages in our target working areas). The composition of the PNCC includes the directors or deputy of all departments at the provincial level, district leaders, NGOs/IOs, LNGOs and is chaired by the provincial governor.

[1] Medicam is NGO network for health in Cambodia

Reproductive Health Promotion Working Group (RHPWG)
The CSP PM has been the vice-chairman of the RHPWG since November 2003. This working group, initiated by MEDiCAM, has financial support from the Policy Project. It has developed a work plan, allocated duties for small sub- groups and set up the schedule for meetings on a bi-monthly basis. The working group is composed of 12 member NGOs of MEDiCAM working in the reproductive health sector. The purpose of the working group is to advocate/lobby decision makers in recognizing the policy gaps about the lack of male involvement in RH and supporting development of new guidelines for male involvement in RH.

Provincial Coordinating Committee Meeting
CSP staff attends the ProCoCom meeting at the KPT PHD every two months. The PHD director facilitates the entire ProCoCom meeting and shares new health messages with the participants. The members of ProCoCom include all the OD directors, Directors of all referral hospitals, Directors of all departments of the PHD and all representatives of IOs, NGOs and LNGOs.

District Technical Health meeting
Early every month, the OD director invites representatives of NGOs that work in health sector to join meetings with OD, HC chiefs, other department's chief such as EPI, Malaria, TB, STD& HIV/AIDS, and etc. The HC Coordinator participates in these meetings every month. The purpose of these meetings is to strengthen collaboration, share current issues faced, broadcast circulars from the MoH or PHD and solve problems encountered.

Organizational capacity assessment
Although ADRA has not had an official review or assessment of organization capacity since 1997, ADRA is operating from a three year Strategic Plan that was developed by ADRA Administration, senior staff members, and the ADRA board in 2002. This plan was developed using the *balanced scorecard* method including self assessment of organization capacity and developing an action plan to achieve capacity in weak areas. The action plan is in the 2nd year of three and is reviewed by PROCOM bi-annual and by the board annually. Plans, although behind schedule due to senior administrative staff turnover, is on target and progressing

Other relevant management systems
The Project Management Committee (PMC) has met as needed throughout the project year. The project management has approached any issues or challenges as a team and thereby ensured a broad input on the matter while using these opportunities to build organizational capacity.

ADRA Cambodia has established a Programs Committee (ProCom) where all project management and advisory staff meet tri-annual to share project management strategies, successful development experiences and discuss & solve administrative issues.

VII ACTIVITY TIMELINE

Health Programs Workplan

Program Component/ Strategic Objective	Workplan Activity	Performance Indicator	Qtr 1 2004	Qtr2 2005	Qtr3 2005	Qtr4 2005	Person Responsib
-Maternal& New born care, Birth spacing and Nutrition	Mother club Training	60Mothers club chief will be trained at the end of quarter 4	X	X	X	X	PA,PM,APM and 5 teams
Maternal & Newborn Care, Birth Spacing Nutrition, & Immunization	Mother club day	-188 mothers attended mother club days on Quarter one -752 mothers will attend mothers club day on Quarter 2	X		X		PM and APM and 5 teams
Nutrition	NERP in Kgnorm, Protong ,Trapaing Chranieng, Daun Pen,and Sralao Tong village	1st to 5th round NERP will be conducted at the end of quarter 3	X	X	X		Hearth Nutrition GTZ
Nutrition	GMP in 20 CFV	Monthly Growth Monitoring in 20 CFV	X	X	X	X	The 5 teams and CC
Hearth Nutrition	PDI in Snor&Tourl Sangke CFV	Key Informant Interview, Focus Group discussion, Survey on Child feeding, Hygiene, Child care and Health Seeking practice of mothers in 2 CFV were found	X				PA,PM, APM, MEO the 5 teams
Maternal & Newborn Care, Birth Spacing Nutrition, & Immunization	Village Health Day	Health promotion, Growth Monitoring, Counseling, Consultation and EPI, Vitamin A and Iron tablets distribution	X	X	X	X	PA,PM,APM,HC Coordinator HC and Field teams
Maternal & Newborn Care, Birth Spacing Nutrition, & Immunization	LQAS for CBDRN project	Data of birth spacing indicators will be collected	X		X		BSO, CC and MEO
Maternal & Newborn Care, Birth Spacing Nutrition, & Immunization	TBA Training 2	92 TBAs will attend the training	X				APM, HCM and the 5 teams
Maternal & Newborn Care, Birth Spacing Nutrition, & Immunization	4th LQAS Survey	Project indicators will be measured		X			MEO and the 5 teams
Maternal & Newborn Care, Birth Spacing Nutrition, & Immunization	HC Assessment	10 HC will be assessed		X		X	HCCo,OD and MEO
Maternal & Newborn Care, Birth Spacing Nutrition, & Immunization	TBA Training 3	92 TBAs will attend the training			X		APM, HCM and the 5 teams
Maternal & Newborn Care, Birth							

VIII. ITEMS WITH POTENTIAL FOR SCALE UP

Most Significant Change (MSC) Qualitative Monitoring Tool

The Monitoring, Evaluation and Activity Officer attended a Pilot MSC evaluation conducted in ADRA Laos. He was able to observe first hand the strengths and weaknesses of this tool and has set up the system for the CSP. The Most Significant Change monitoring tools is an innovative way of monitoring a project away from traditional "indicators". Instead, the focus of the system is on the identification of significant change as perceived and interpreted by the various participants. It relies on the use of qualitative, not quantitative, information. It is a participatory monitoring system in the course of developing an evolutionary perspective on learning within organisations. The MSC has been integrated in the Project Progress Monitoring system and has come up with two most significant stories from the community to date. (See appendix 9)

"Drip Feeding" Training System

The scheduling of training in Phase II has changed from what was originally planned. CSP staff learned of the "Drip Feeding" method of training and recognized that the benefits of better trainee retention would make a significant impact on the project. Now, all training is divided into 2-4 parts and each part is conducted every 4 months. CHE and TBA training lessons had divided into 4 parts and HCMC training lesson had divided into 2 parts. Project experience in the Phase I area showed that volunteers had difficulty to absorb many materials during one long training session. Volunteers can learn more if the training was given piecemeal and has more practicing time. These drip-feed training sessions are in field settings with live practices more often, depending on the materials and discretion of the trainer.

IX. OTHER RELEVANT ASPECT OF THE PROGRAM

Volunteer

A new international staff will be joining the program as a volunteer/intern for the next 18 months as planned in the DIP and budget, although a bit later than planned. The volunteer selected is from Nigeria and has just completed an MPH with an emphasis in Health Promotion in the Philippines.

The project areas that the new staff has been hired to focus her work on are to 1) work with Monitoring and Evaluation and Activities officer in developing a simplified data management system according to the project requirements, 2) Conduct, analyze and report participatory qualitative (and some quantitative) research, and 3) assist the team in documentation of activities and report. Working with the project manager and advisor as needed, she will be a team member joining in other project activity both to learn and contribute.

X. APPENDIXES

1. Third LQAS report (Methodology, data presentation, and analysis from workshop)

A. Sample Design

57 respondents were randomly selected from each health center supervision area by using the cluster identification worksheet. A sample of 19 was required for each questionnaire; therefore the total interviewees of the five HC supervision areas are 285 individuals to calculate a coverage proportion over the each HC supervision area.

B. Questionnaires

The questionnaires used the previous surveyed questions from the first LQAS, and were rechecked on the Khmer translation from English with CS staff, CCs, and HC staff, to make sure the questionnaires are clear. When the instruments were done the pre-test was taken place in the village nearby with the intended target group. The types of questionnaires were used as below table;

Table 1.Target Population Groups and Catchments Areas

N0	Target group	Supervision Area
1	❒ Non-pregnant women age (15-49 years) 19 individuals ❒ Mothers with children age 0-11 months 19 individuals ❒ Mothers with children age 12-23 months 19 individuals The total **57 respondents.**	❒ Balaing health center supervision area 12 villages were interviewed
2	❒ Men and women of reproductive age (15-49 years) 19 individuals ❒ Mothers with children age 0-11 months 19 individuals ❒ Mothers with children age 12-23 months 19 individuals The total **57 respondents**.	❒ Boeung health center supervision area 5 villages were interviewed
3	❒ Men and women of reproductive age (15-49 years) 19 individuals ❒ Mothers with children age 0-11 months 19 individuals ❒ Mothers with children age 12-23 months 19 individuals The total **57 respondents**.	❒ Kreul health center supervision area villages were interviewed
4	❒ Men and women of reproductive age (15-49 years) 19 individuals ❒ Mothers with children age 0-11 months 19 individuals ❒ Mothers with children age 12-23 months 19 individuals The total **57 respondents**.	❒ Protong health center supervision area villages were interviewed
5	❒ Men and women of reproductive age (15-49 years) 19 individuals ❒ Mothers with children age 0-11 months 19 individuals ❒ Mothers with children age 12-23 months 19 individuals The total **57 respondents**.	❒Tang kork health center supervision area 13 villages were interviewed

More detailed

Table2. Types of Respondents and Questionnaire Modules Included in the Survey

Questionnaire module	Type of Respondent		
	Women (non-pregnant) and Men Age 15-49 years	Mothers with children 0-11 months	Mothers with children 12-23 months
Background	X	X	X
Nutrition		X	X
Immunization	X		X
Birth Spacing	X	X	X
Prenatal/Delivery Care		X	
HIV/AIDS	X		

C. Data Collection

The survey teams were assigned into ten two person teams, one interviewer was moderator and another note taker. When each team arrived at a village, the team met the village leaders and volunteers to review the existing map drawn with village, HC chief and volunteers. Then they subdivided the village into sections depending on VHV/CHE's household responsibilities, approximately 30-35 households per section. For the section selection, in the first step the interviewers wrote each section on a separate piece of paper, placed them in a cap and then randomly selected one piece of paper out of the cap. In the second step, the interviewers wrote numbers equal to the total household numbers on a separate piece of paper, placed them in a hat, and then randomly selected one piece of paper from the cap.

The interviewers went to the randomly selected starting house and if they found that eligible respondent was not available, went to the next nearest household from the entrance to the household they were at and continued this process until they found the informant type they were looking for.

D. Data Entry

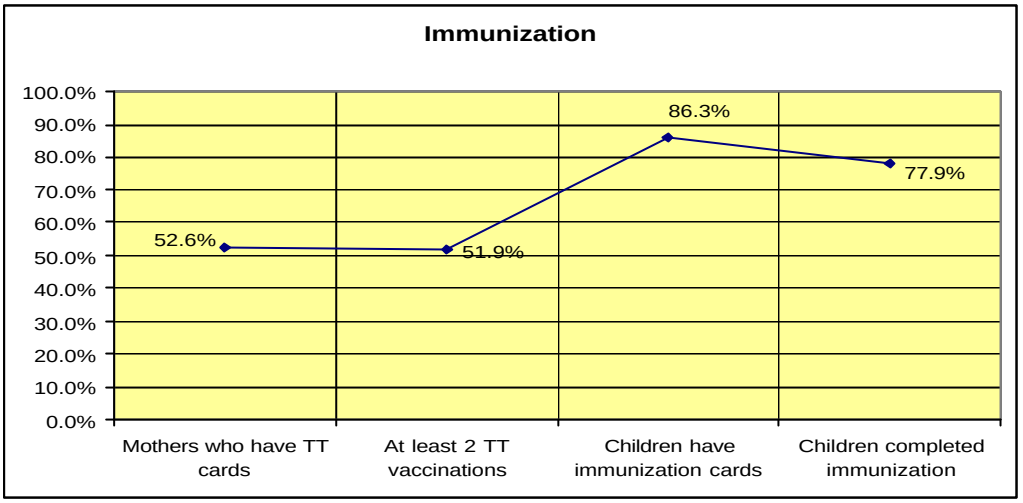
All the completed questionnaires were first checked by supervisors on site before taking to the CSP Kampong Thmor Office every day. After finishing the survey all the questionnaires were hand tabulated by the Child Survival staff and CCs at very beginning of May, 2004.

The secondary data was entered to the computer by using Microsoft Excel to develop graphics and summary table results then imported to Microsoft word for report writing and Power point for presentation.

III. RESULTS OF FINDINGS

The results in this section concern response to questions asked of three different types of respondents: Married non pregnant women and men aged 15-49, mothers with children aged 0-12 months and mothers with children aged 12-23 months. This report mainly presents effects of data on health behaviors and knowledge within the entire program area and supervision area

A. Immunization (Non-pregnant / 12-23ms)

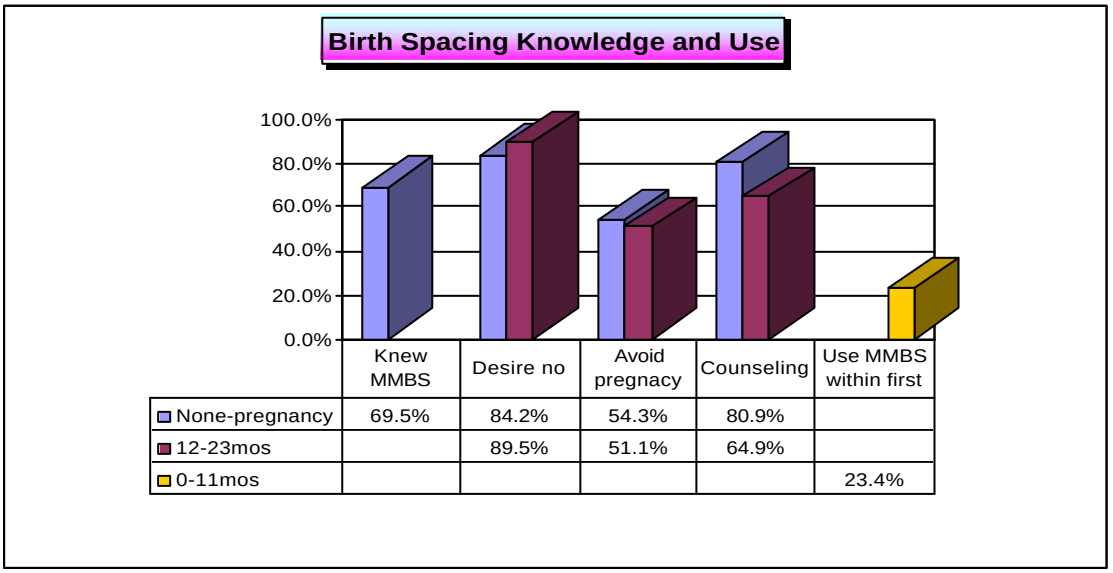


The project's indicator is to increase from 9 to 40% mothers with children age 0-23 months. The percentages of the mothers have TT vaccination cards 52.9% (50/95) but only 51.9% (40/77) of the mothers received at least two TT vaccinations. This figure had slightly lower than the second LQAS.

It was found that many mothers lost their immunization cards. Our strategies are to provide the HCs with a master register book and supply new cards for mothers who lost their cards. The project thru community volunteers will provide education to mothers about the importance of immunization.

Whereas the percentage of children who had vaccination cards was 86.3% (82/95), it was lower than either. And the children completely vaccinated were 77.9% (74/95). Having cards does not mean complete immunization. Complete immunization is based on age the children, based on EPI guidelines.

B. Birth Spacing



	Knew MMBS	Desire no	Avoid pregnacy	Counseling	Use MMBS within first
None-pregnancy	69.5%	84.2%	54.3%	80.9%	
12-23mos		89.5%	51.1%	64.9%	
0-11mos					23.4%

WRA reporting that they knew modern birth spacing methods at 69.5% (66/95) was increased compared with second LQAS report 51.9%. The married Non-pregnant women who desire no children in the next 2

years 84.2% (80/95) was slightly lower than mothers with children age 12-23 months who were interviewed, which was 89.5% (85/95). This is because mothers with 12-23 month old babies are still busy with their babies and don't want to get pregnant yet.

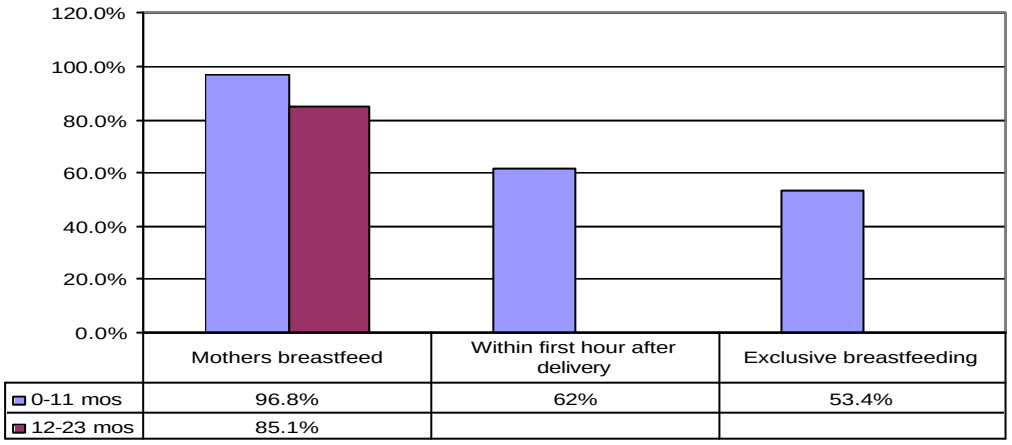
Whereas the percentage of the married non-pregnant women who want to avoid or delay pregnancies who used modern birth spacing methods was 54.3%, it was not far different between mothers with children age 12-23 months, it was 51.1% (45/88)

There was 80.9% (38/47) of married non-pregnant women and 64.9% (37/57) mothers with children age 12-23 months who received birth spacing counseling during using modern birth spacing methods.

23.4% (11/47) of women who started using birth spacing methods within the first three months after delivery; it was gradually increased from phase to phase as seen in the LQAS presentation on the section of this report. (See page 6, Table 1.a.2 Mothers with children 0-11 months).

C. Nutrition

C.1. Breastfeeding

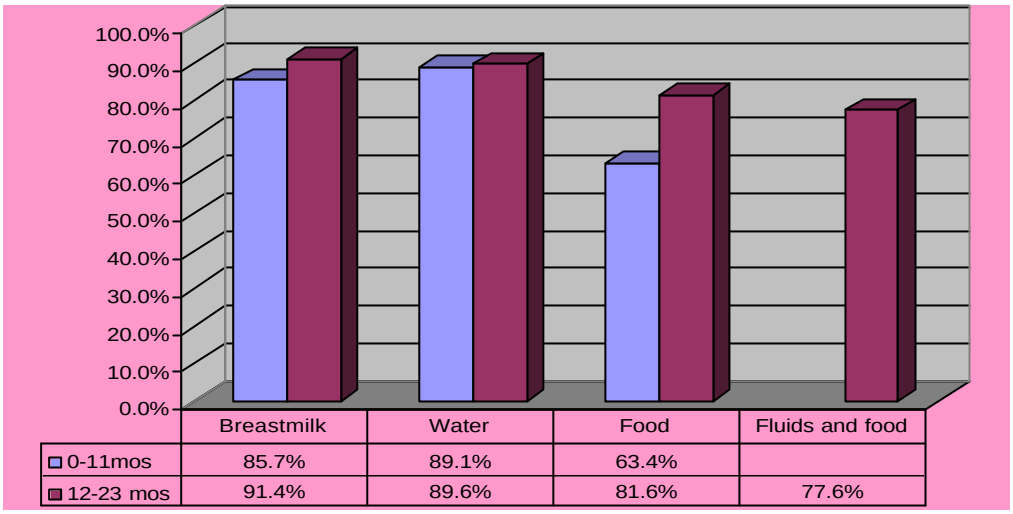


When the survey was conducted, 96.8% (91/94) and 85.1% (80/94) of mothers with children age 0-11 months and age 12-23 months respectively said that they have breastfed their children Even though the percentage of mothers reporting to have breastfed to their children was very high, the mothers (0-11 ms) who initiated breastfeeding with colostrums within the first hour after delivery was 62% (59/95). Nevertheless, it was only 53.4% of mothers who exclusively breastfeed that was lower than the percent of mother who have continued breastfeeding.

Three underlying reasons were identified for low exclusive breastfeeding: First, because of the tradition enforced by grandmothers that mothers give additional fluid to the baby. Second, these mothers are working mothers supporting their family to survive on a low daily income. Most of the time, these mothers do not have the choice but to leave their babies with grandmother or elder siblings to make a living. Third, these mothers do not understand the importance of six months exclusive breastfeeding.

The issue of working mothers is addressed in the link to the partner home gardening project. As well as providing a daily income by selling produce, the home gardening also can supply nutritious food for the family. Solution for the first and last issues above will be continuation of health promotion focusing on benefits of exclusive breastfeeding by role modeling, home visits and BCC strategy campaigns targeting grandmothers, siblings and mothers.

C.2. Food or liquid given during illness



The percentage of the mothers with children age 0-11 months who reported continued breastfeeding during their children's illness was 85.7% (54/63) and for mothers with children age 12-23 months it was 91.4% (64/70). It seems to be higher than the mothers in group children age 0-11months. Also the percentage of mothers with children age 0-11 months was 89.1% (41/46) who continued giving water to their children during illness was almost the same as mothers with children age 12-23 months at 89.6% (69/77). For food giving during illness, the percentage of the mothers of children in age group 0-11 months was 63.4% (26/41) and children 12-23 months was 81.6% (62/76), whereas the aggregated results of the mothers who continued giving fluids and food for their children during illness in age group 12-23 months was only 77.6% (59/76).

One of the reasons identified was that six months breastfeeding is promoted and practiced by some during the first year which would result in low incidences of illnesses during exclusive breast feeding period.

C.3. Weight at birth, Iron and Vitamin-A distribution

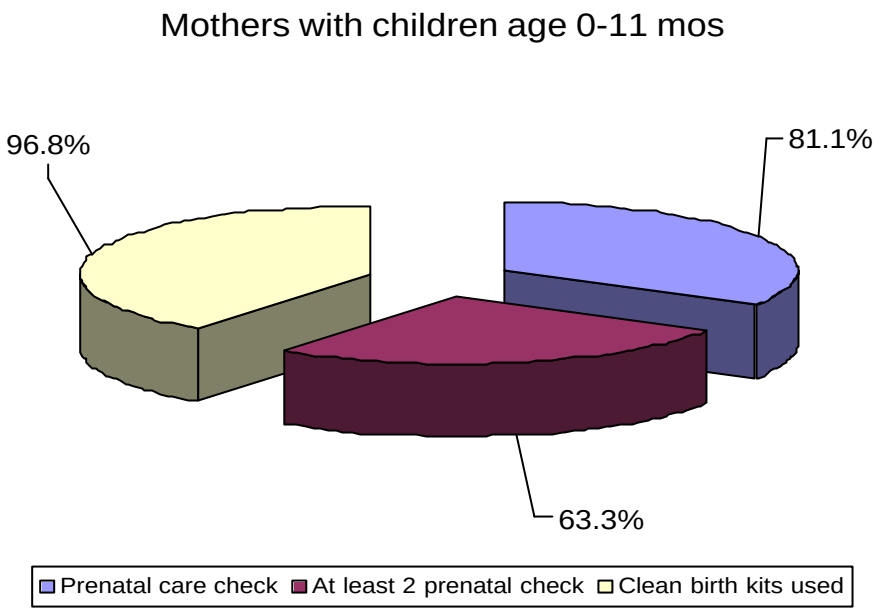
Indicator	Numerator	Denominator	Percent
✳Babies weighed at birth within 24 hours after delivery (0-11ms)	87	95	91.6
✳Pregnant women who receive iron tablets (0-11ms)	80	95	84.2
✳Mothers received vitamin-A dose in the first two months after delivery (0-11ms)	80	95	84.2
✳Children received vitamin-A at least one capsule in the last 6 months (12-23ms)	92	95	96.8

The percentage of the babies weighed at birth was 91.6% (87/95); this was recorded on immunization cards. It seems to be high figure and would be because all TBAs in the project catchment areas have baby weighing scale and have been trained on this.

The percentage of pregnant women who received Iron at the health center and immunization outreach activities site was 84.2% (80/95). For the mothers who received a Vitamin-A dose in the first two months after delivery the percentage was 84.2% (80/95). Of mothers who were asked, the percentage of the children who were received Vitamin- A at least one capsule in the last 6 months was 96.8% (92/95). The source of Vitamin-A capsules is from the national campaign every 6 months at the community level. Project staff plays a key role in community mobilization, facilitating data records, and sometimes assisting HCs in reaching mothers who were not able to come to the HCs.

D. Maternal and Newborn Care

D. 1. Prenatal/Delivery Care

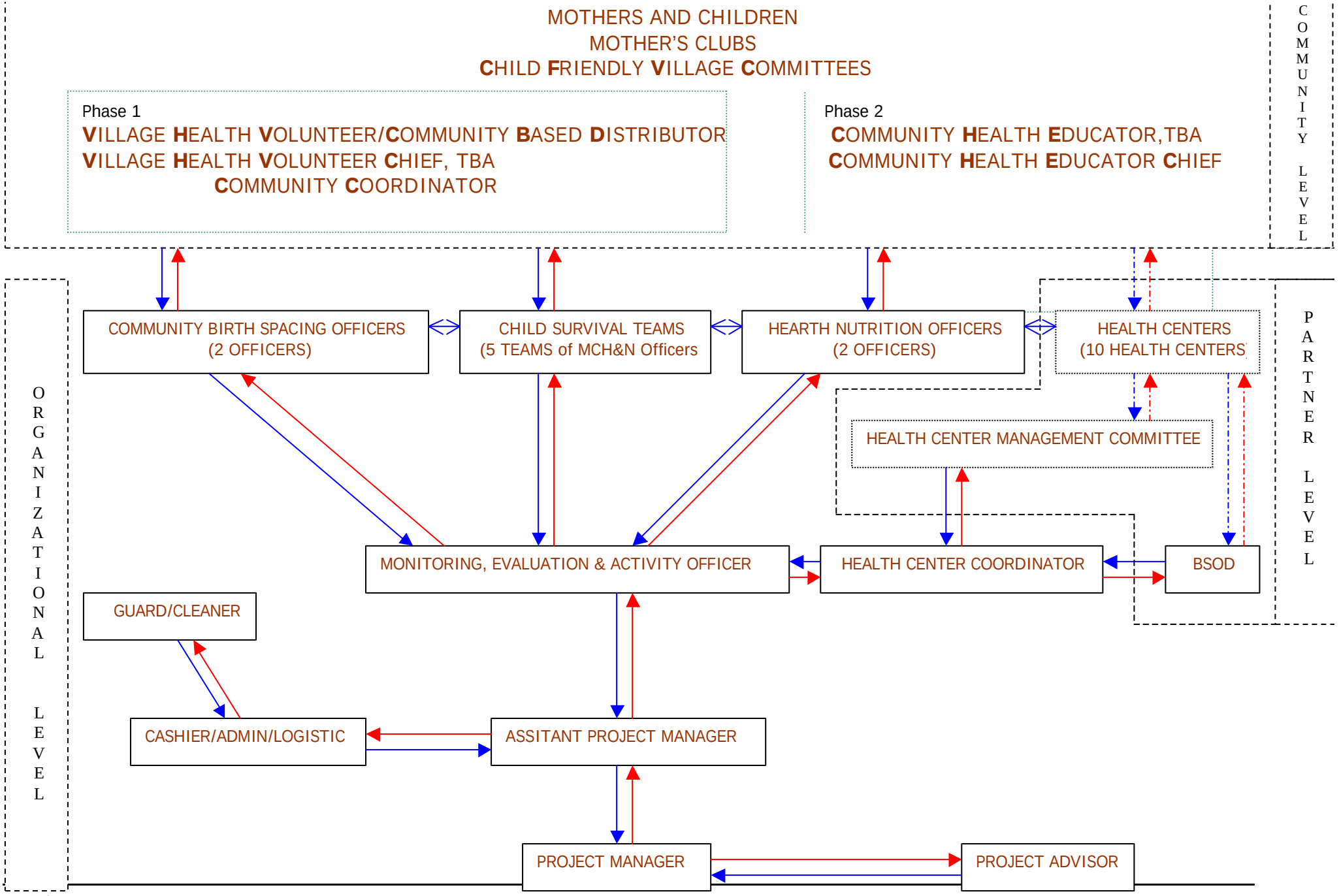


The mothers, who were asked, reported that 81.1% (77/95) received prenatal care check ups during pregnancy. Also pregnant women who received at least two prenatal cares during their pregnancies by HCMs were 63.3% (57/90). 96.8% (92/95) of pregnant women delivered babies with only traditional birth attendants (TBAs) in attendance that used clean birth kits.

D.2. HIV/AIDS Awareness (Women and Men age 15-49 years)

Indicator	Numerator	Denominator	Percent
Women have ever heard of AIDS	94	95	98.9
✳WRA with children< 2 years who knew at least two ways that HIV/AIDS is spread	73	95	76.8
Men have ever heard of AIDS	95	95	100
✳Men age 15-65 who knew at least two ways that HIV/AIDS is spread	77	95	81

As noted in the LQAS results presented earlier, this represents an increase in knowledge. To continue working towards the objectives, as well as continuing to work with VHVs & CHEs in health promotion, ADRA Cambodia will examine lessons learned in media and other avenues in its HIVAIDS project to determine if there are some cost effective ways of working with mass media in the project area to enhance community work.


MOTHERS AND CHILDREN
MOTHER'S CLUBS
CHILD FRIENDLY VILLAGE COMMITTEES
Phase 1
VILLAGE HEALTH VOLUNTEER/COMMUNITY BASED DISTRIBUTOR
VILLAGE HEALTH VOLUNTEER CHIEF, TBA
COMMUNITY COORDINATOR
Phase 2
COMMUNITY HEALTH EDUCATOR,TBA
COMMUNITY HEALTH EDUCATOR CHIEF
COMMUNITY LEVEL
COMMUNITY BIRTH SPACING OFFICERS (2 OFFICERS)
CHILD SURVIVAL TEAMS (5 TEAMS of MCH&N Officers
HEARTH NUTRITION OFFICERS (2 OFFICERS)
HEALTH CENTERS (10 HEALTH CENTERS
HEALTH CENTER MANAGEMENT COMMITTEE
MONITORING, EVALUATION & ACTIVITY OFFICER
HEALTH CENTER COORDINATOR
BSOD
PARTNER LEVEL
GUARD/CLEANER
CASHIER/ADMIN/LOGISTIC
ASSITANT PROJECT MANAGER
PROJECT MANAGER
PROJECT ADVISOR
ORGANIZATIONAL LEVEL

3. Abstract Submitted to Global Health Council

Health Systems: Putting Pieces Together
Global Health Council's 32nd Annual Conference
May 31-June 3, 2005, Washington, DC

Abstract Template

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Gender:	male
Abstract Format:	FORMAT2
Abstract Title:	Involving Stakeholders through Innovative Community Initiatives to Improve Mother Child Health
Designated Presenter:	Leonard Uisetiawan
Submission Type:	INDIVIDUAL
Session:	PANEL
Submission Category:	STAKEHOLDER
Key Issue:	CHILD
Learn Obj:	By the end of the session, participants will be able to identify a health promotion strategy of involving stakeholders through role modeling and personal relationships.
Background:	The 5 year Child Survival XVII project in the Baray-Santuk Operational district of Kompong Thom, Cambodia has the objective to improve the quality of health and reduce the morbidity and mortality of 39,926 women of reproductive age and children under five. The project works in 10 Health Center Catchment areas in interventions of nutrition, immunization, birth spacing, and maternal and newborn care through strategies of village level volunteers, health system capacity building, partnerships, and community-based initiatives.
Design / Methods:	The Child Friendly Village (CFV) is an initiative focusing on communities' traditional structures empowering communities to establish high standards of health behavior as the norm. After the project selected 20 villages based on access to health centers and poor health conditions, local leaders established CFV committees with the goal of making their village a CFV. These committees use interventions of behavioral change through role models and personal health

promotion, with Mother's Clubs, Integrated Health days, and nutrition programs supported by the project. The title "Child Friendly Village" is given to these villages, and any others, that meet preset mother child health related indicators.

Results/Outcome: After a baseline done using the 30 cluster method, the project has used Lot Quality Assurance Sampling (LQAS) in monitoring and quality control of this project. The first LQAS was three months after the Child Friendly Village Initiative started. The third LQAS report included 285 respondents from 57 clusters and 19 samples. Data collected was treated statistically and interpreted in comparison with previous LQAS.

Indicators Jan. 03 Aug. 03 Apr. 04 Breastfeeding begins within 1 hour after delivery 28.4% 48.4% 62% Mothers who gave usual or more fluids and food to a sick child 58.2% 46.8% 77.6% Breastfeeding continued during illness 82.2% 87.3% 91.4% Children with complete vaccinations 47.4% 73.6% 77.9% Women who initiated using modern birth spacing method within the first three months following pregnancy 12.1% 15% 23.4% Women who received counseling at the health center and community level 43.2% 39.5% 80.9%

Partners: Baray Santuk Operational District and 10 Health Centers

Conclusion: Focused stakeholder involvement contributes to community behavior change as community leaders support health interventions and establish high standards of health behavior as the norm.

Additional Authors: Debora Herold, Mark Schwisow, Ann Stickle

Bio: Leonard S. Uisetiawan Areas of Interest: Mobile clinic, Dispensary, Health Access, Supplementary Feeding, Maternal and Child Health, EPI, Family Planning, Revolving Drug Funds, Health Policy, Administration, Management, Cost Recovery Qualification: More than 6 years of experience in non-governmental organization in emergency and development programs, particularly in the areas of participatory, development, education, and governance. Skills in multi-sectoral project management and human resource development. Assisted in the design, implementation, monitoring and evaluation for AUSAID, USAID/OFDA and OCHA funded program. Education: Medical Doctor-Manila Central University School of Medicine, April 1996 BSc. Medical Technology-Adventist University of the Philippine, March 1992 Certificate of Computer Proficiency-De La Salle University Manila, April 1991 Experiences: 2004 Provincial Projects Advisor: ADRA Cambodia, Kompong Thom, Cambodia 2003 Medical Consultant: IMC (International Medical Corps) West Kalimantan, Indonesia 2002 Medical Officer, Save the Children-United Kingdom, West Kalimantan, Indonesia 2001 Medical Coordinator, IMC (International Medical Corps) West Kalimantan, Indonesia Medical Officer, IMC (International Medical Corps) North Sulawesi, Indonesia 2000 Medical Officer, MSF-F (Medecins Sans Frontieres-France), North Sulawesi, Indonesia 1999-2000 Officer-in-charge, Government Secondary Health Care Facility, North Maluku, Indonesia 1998-1999 Director, Secondary Health Care Faciltiy, Central Maluku, Indonesia 1997-1998 Industrial Physician, Sheraton International Hotel, West Java, Indonesia 1992-1996 Volunteer, Gabay Medisina (Medical NGO), Luzon, Philippines Accomplishments: I have successfully advocated for getting internally displaced persons in West Kalimantan into tertiary care. With the collaboration of all NGO's and government officials in the area, we came up with a formula that the IDP's could use to get into free governmental hospital services. This is necessary while the IDP's are

waiting for their Indonesian identity cards to be processed. I also wrote the Memorandum of Understanding between the NGO's and the governmental hospital. I assisted the Field Manager of IMC, West Kalimantan is writing a primary health care project proposal. The project focuses on strengthening secondary and primary health care facilities by promoting financially sustainable policies. The emphasis in the primary health care project is to help the health institutions to become autonomous by strengthening financial management and creating a cost recovery mechanism using revolving drug funds and user fees. I pioneered an International Medical Corps program in North Sulawesi and West Kalimantan; setting up the office and its management, recruiting the medical team and setting up mobile medical teams and a mobile clinic for emergency responses. Two mobiles clinics were set up and covered a population of 205,000 IDP's. We provided curative care, contraceptives, educational campaigns focusing on integrated management of childhood illnesses and reproductive health. We collaborated with the government health department to provide EPI coverage for the IDP's and other international NGO's to provide a nutritional feeding program for the children. I developed a system of health surveillance in North Sulawesi that covered 8 IDP camps. We set up a fast response medical team to treat the people in these camps. I developed a community health care and school based program for Save the Children that benefited 16,652 IDP's and 1110 children. The program predominantly used a participatory approach where the communities would be organized and take action on different health problems arising in their communities. We provided the training and facilitation of these community meetings. Community health centers were run by cadres that we trained. We set up village pharmacies and school-based health promotional campaigns. I set up and managed a dispensary in an emergency relief operation with MSF. We provided curative care, did minor operations, nutritional feeding programs, pre and post-natal care, family planning and treated and gave community education on sexually transmitted diseases. The dispensary benefited 30,000 IDP's. We successfully conducted a mass measles immunization that covered 80,000 children under the age of five. I also developed Health Access by networking with hospitals, primary and secondary health care facilities, government and private facilities throughout North Sulawesi. Technical Skills: Management, program design, implementation, monitoring, evaluation and training. Languages: Indonesia (native), English (advanced), Filipino (advanced), Malay (good)

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4. Abstract Submitted to MEDiCAM for NGO Consultation on Child Survival

September 8 – 10, 2004

CHILD SURVIVAL – BREAST FEEDING MOTHERS' BEHAVIOR CHANGE THROUGH COMMUNITY EMPOWERMENT. Pheng Meas, Project Manager; Leonard Uisetiawan, Project Advisor; Ann Stickle, Associate Director; Mark Schwisow, Country Director

Background/Problem: The health status of children in Baray-Santuk Operational District (BSOD) is among the poorest anywhere. The most recent DHS 2000 estimate an IMR of 64.5 in 1,000 and U5MR of 98.8 in 1,000. Causes of death among children include malnutrition, diarrhea, ARI and vaccine-preventable diseases. The project baseline shows that 41.6% of children from 0-23 months in BSOD are underweight. Most child health problems are rooted in cultural beliefs, such as not breastfeeding in the first 3 days, roasting, and withholding fluids from children with diarrhea. **Duration**:5 years (01/10/01 to 30/09/06); **Location**:BSOD, Kg. Thom province; **Scale:**10 Health Center (HC) supervision areas. **Objectives:** To improve the quality of health and reduce the morbidity and mortality of children under five in BSOD. **Design & Strategy**:While supporting and training existing care structures of Village Health Volunteers, TBAs and HCMCs, in the areas of nutrition, immunization, birth spacing and maternal & newborn care, the program focuses efforts on community empowerment through village level initiatives, a main one being the Child Friendly Village (CFV), where the desired practices are being promoted and evaluated routinely. Each targeted CFV has a steering committee composed of HC staff, village volunteers, TBAs, Village Chiefs, and women's association representatives. The CFV is then linked to other community components such as HCs through its members. The title of CFV is given to villages that successfully meet all indicators in promoting Child Health. Village Volunteers and TBAs serves as role models and educators in this initiative. They receive regular training support from ADRA staff in combating wrong practices and beliefs. Training Curricula is developed based on "needs assessment" and community feedback ensuring sensitivity to community needs. **Program Outcome:** ADRA is implementing Lot Quality Assurance Sampling (LQAS) in monitoring and quality control of this project. The latest LQAS report included 285 randomly selected respondents from 5 HC supervision areas. Data collected were treated statistically and interpreted in comparison with previous LQAS. The table below presents effects of community empowerment on health behaviors and knowledge within the selected program areas in these 5 HC supervision areas.

Indicators	*Jan. 03*	*Aug.03*	*April 04*
Breastfeeding begins within 1 hour after delivery	28.4%	48.4%	62%
Breastfeeding exclusive for 6 months	47.9%	32.2%	53.4%
Children given liquid when ill	82.1%	86.5%	89.1%
Babies weighed within 24 hrs after delivery	61.6%	83.2%	91.6%
Mother received VAC within 2 mo after delivery	43.2%	67.4%	84.2%
Children received VAC in the last 6 months	75.5%	91.6%	96.8%
Children with complete Vaccination	47.4%	73.6%	77.9%
Breastfeeding continued with illness	82.2%	87.3%	91.4%

Potential for Scale up: The project training manuals had been requested by MRD/Rural Health Care department for dissemination. MOH/BSOD had expressed their interest and commitment to sustain CFVs during the recent project MTE.

April 2004, to sustain this community empowerment effort and will take more active role in the second phase of the project.

Cost of Project (minus indirect)	Direct Beneficiary Population	Number of Direct Beneficiaries	Project Duration
1,073,577	WRA&children<5	39,926	5 years

Submitted by:

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5. Positive Deviant Inquiry Tools

I Key Informant Guide

a) Name of Group**:**
(Each team supplied their name and specific target group)

b) Goal: To explore the community child caring and health seeking practices

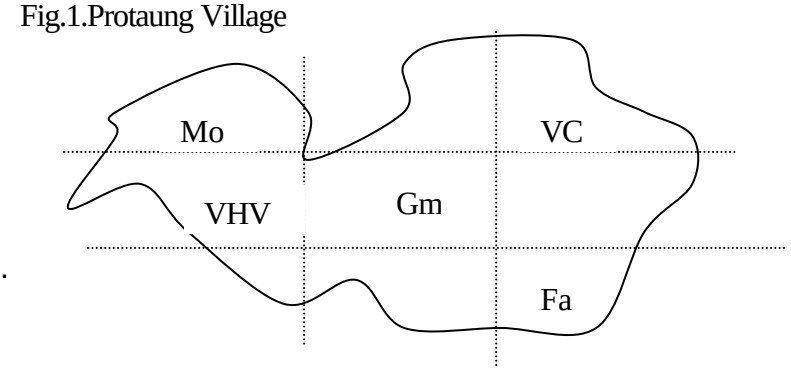
c) Objective:
i) To identify the child care practices of the community
ii) To identify the health seeking behaviors in the community

d) Chosen Theory: Theory of Planned Behavior

e) Theoretical Sampling
i) Target Group:
(1) Mother (Mo)
(2) Father (Fa)
(3) Grandmother (Gm)
(4) Village Chief (VC)
(5) Village Health Volunteer (VHV)

Mother, father and grandmother informants will come from different families and different villages. Village Chief and Village Volunteer Key informants preferred to have family and children. Key informant will be chosen randomly across a village with the aid as bellow.

Fig.1.Protaung Village



The interview will start from mother (Mo) key informant to village volunteer (VHV) key informant (i to v), and then will back again to Mother (Mo) with new random setting, until saturation occur.

ii) Division of labor
(1) Group A will interview Mother (Mo)
(2) Group B will interview Father (Fa)
(3) Group C will interview Grandmother (Gm)
(4) Group D will interview Village Chief (VC)
(5) Group E will interview Village Volunteer (VHV)

II Key Informant Outline

a) Introduction**:** Hello, my name is _____, I am working with ADRA Kampong Thmor. We want to talk with you because we think your information is very important to us. Right now we want to do something for undernourished children in your village. We are developing a nutrition program for Kampong Thmor. But before that we need to know the childcare practices and understand the health seeking behavior of people here.

I will write and record what you say. This is important to help me remember your opinion and beliefs, but will not be used for any other purposes. I won't identify your name in my studies, or giving your name to a third party. It will be okay if don't want me to record you voice or write down your statement. You are free also to stop this conversation anytime you wish. I will ask you to put your thumb mark or sign in this paper if you agree. This paper is just an agreement between you and me that you allowed me to record your statement and will be used it in developing a nutrition project for Cambodian children. ……..thank you very much!

b) Ice breaker:
My friends usually short cut my name and call me ___, how do you like me to call you?
I have __ children and they are very active and cute. How about your children? (customized this to your style)

c) Interview questions and objectives**:**

i) To identify the child care practices and beliefs of the community

(1) In your community, how do you prepare food for your children?
Probes: a. what food do you think children like to eat?
b. what kinds of food do you think are healthy for the children?
c. where do mothers get healthy food for the children?
d. What do you think about a mother who gets her children food from the pond, rice field or river?

(2) Normally, how often do you wash your hands and when?
Probes: a. what makes you think that you need to wash your hand before eating?
b. what will others think if you don't wash your hands?

(3) How often are children bathed?
Probes: a. what do you feel if your children do not bath for a day.
b. what do you think of a mother who does not bath her children daily?
c. what benefit do you think if the children bathed daily?

(4) How often are children's hands washed?
Probes: a. how difficult is it to wash children's hand?
b. what do you think makes children enjoy washing their hands?

(5) How many hours are you apart from your children during the day?

Probes: a. what do you feel when you are being away from your children?
b. what do you do while away from your children?
c. what makes you spend time away from your children?

(6) Who watches your children other than you?
Probes: a. whom do you trust the most in caring your children?
b. do you have always someone to care your children?

(7) Do you encourage your child to play with other children?
Probes: a. what do you expect from your children playing with other children?
b. what do you think if your children do not play with other children?

(8) When do you play with your child?
Probes: a. how do you find time for playing with your children?
b. what are the problems if you spend time playing with your children?
c. what is your opinion about playing with your own child?

(9) What do you think is the most important in a child's needs?
Probes: a. how important is it?
b. what do you think about child who do not have it?

(10) What does your husband do for the children in the household?
Probes: a. how do you feel about it?
b. what is your opinion about being a good father for the children?

ii) To identify the health seeking behaviors and belief in the community

(1) What illnesses most concern parents in your community?
Probes: a. what do you think cause children to get that "illness?"
b. what harmful effect that "illness" caused to children?
c. normally, what do you do for children identified with that "illness?"

(2) What other illnesses do children suffer?
Probes: a. How do you know your child is sick?
b. what do other family members want you to do for your sick child?

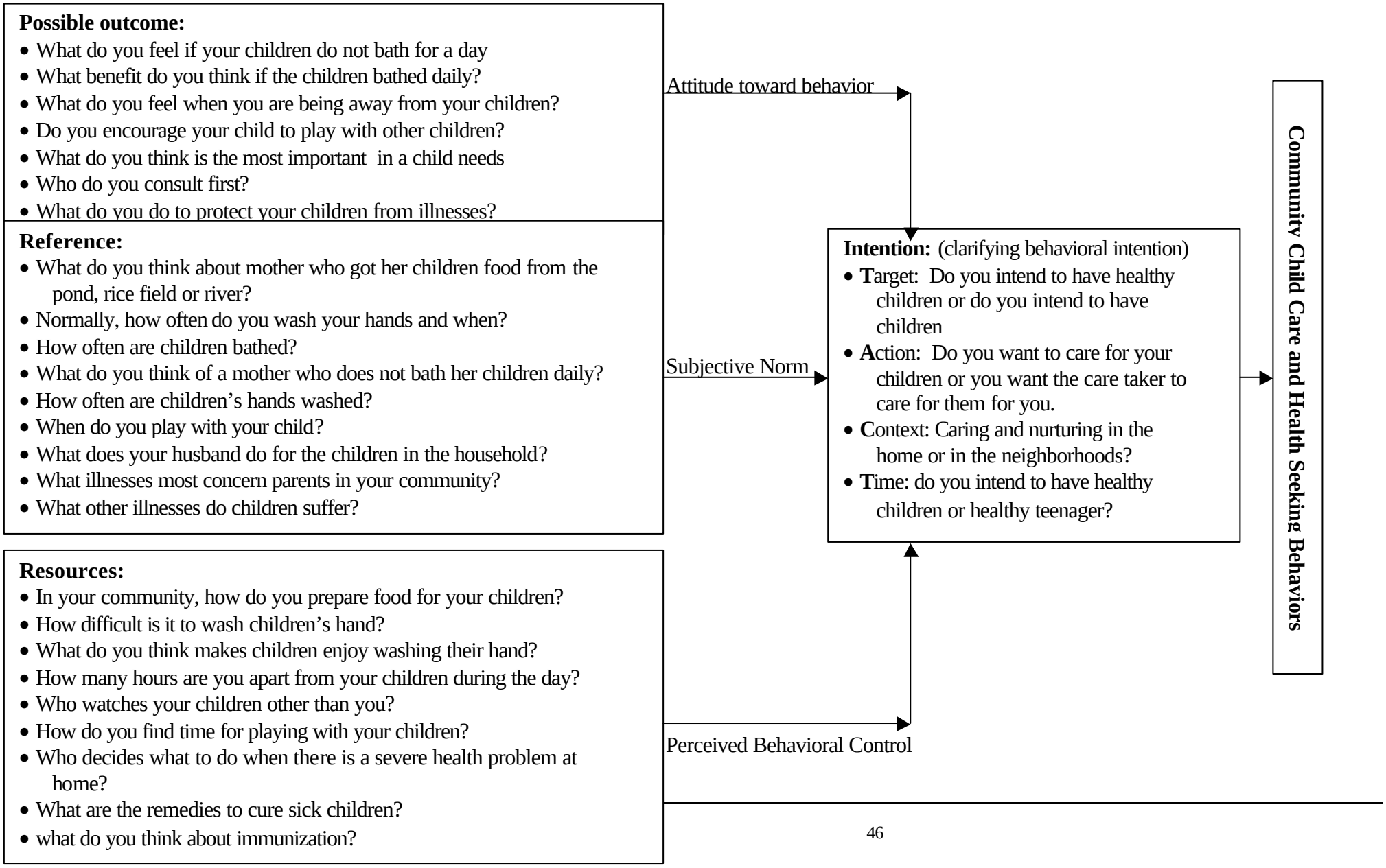
(3) Who do you consult first?
Probes: a. what makes you think to consult your sick child?
b. do you believe that the treatment from the 'consultant' can heal?

(4) Who decides what to do when there is a severe health problem at home?
Probes: a. what other things that you consider in making that decision?
b. what do you think can facilitate your decision?
c. what other things do you think will hinder your decision?

(5) What are the remedies to cure sick children?
Probes: a. how do you think those remedies can cure sick children?
b. what do you think can facilitate you having those remedies?
c. what other problem hinder you from performing those remedies?

(6) What do you do to protect your children from illnesses?
Probes: a. how do you prepare drinking water in your house?
b. how do you keep your house clean?
b. what do you think about immunization?

III Key for Theoretical Questions



a Focus Group Discussion Protocol

A. Situational Background
Community's poor of the poorest are able to rear healthy babies in spite of poverty and high risk environment practices. They have adapted to their living conditions and remarkably developed unique childcare practices in contrast with common practices. These unique practices have successfully brought up healthy babies, and perhaps can become solutions for community malnutrition problems.

B. Purpose of Focus Group
These Focus Group Discussions (FGD) want to understand the common child rearing practices in the community. Together with quantitative and survey data, these FGD should provide us contextual information for feeding, childcare, hygiene and health-seeking behaviors.

C. Focus Group Goal
To explore the child care concepts, beliefs about child rearing, and perceptions about causes of child malnutrition in the community

D. Objectives
- To identify attitudes of the community toward breastfeeding practices
- To identify the complementary feeding practices of community
- To identify the beliefs of community toward malnutrition in children
- To identify the common belief about child caring practices
- To identify community health seeking practices

E. Theoretical Perspective Guiding in Focus Group Discussion
Theory of Planned Behavior (ajzen, 1989)

F. General participants eligibility
- Mothers
- Father
- Grandmother
- Village Chief
- Village Health Volunteers

G. Focus Group Size
A minimum of six (6) and no more than 12 individual per session

H. Length of Focus Group Session
A minimum of one (1) hour, no more than one and one half (1.5) hours

I. Duties of Focus Group Team
Facilitator: CS officer
Co-Facilitator: Health Center Chief
Recorder: CS officer
Observer: Village Health Volunteer chief
Note taker: CS officer
Observer-Security: Community Coordinator
Time Keeper: CS officer

J. Location setup

- Flip Chart – 10 sheets per target group
- Markers -5 per group, different colors
- Tape recorder – 1 set per group (2 cassettes, 2 extra batteries)
- Name tags
- Informed consent (sign 2, one must be given to each participant/one remain in office)
- Floor mats
- Comfortable room temperature
- Small room
- Plenty of natural light
- Refreshments

K.Procedure for conducting the Focus Group

i. Greetings and Introduction
ii. Purpose
iii. Informed consent (verbal and form)
iv. Ground rules
v. Ice breaker
vi. Focus Group Questions
vii. Exit question
viii. Closing

L. Focus Group Questions

To identify attitudes of the community toward breastfeeding practices
1. (supply questions)
Probes : a. (supply probes….minimum 2 probes per questions)

To identify the complementary feeding practices of community
1. (supply questions)
Probes : a. (supply probes….minimum 2 probes per questions)

To identify the beliefs of community toward children malnutrition
1. (supply questions)
Probes : a. (supply probes….minimum 2 probes per questions)

To identify the common belief about child caring practices
1. (supply questions)
Probes : a. (supply probes….minimum 2 probes per questions)

To identify community health seeking practices
1. (supply questions)
Probes : a. (supply probes….minimum 2 probes per questions)

6. Comparison study of VHV and CHE models of working with Village Health Volunteers

Comparison Study of Two Approaches to Working with Village Health Volunteers Used in the Child Survival XVII project of ADRA Cambodia in Kampong Thom province

The following concept paper related to the two community health volunteer approaches of VHV & CHES will be done over the next year to the end of the project by the new expat volunteer, the AD, and the PA, with assistance from the CSP leadership, staff and volunteers.

Concept paper on Comparison Study of VHV and CHE performance

Child Survival XVII Project
(Implementated by ADRA Cambodia)

Key Objective :
To assess and compare the effectiveness of the two different approaches in the Child Survival XVII project (CSP) of using Commune Coordinators (CCs), Village Health Volunteer (VHV) chiefs, and VHVs in Phase I and Community Health Educator (CHE) Chiefs and CHEs in Phase II as key community-based health educators supporting the sustainable delivery of quality health services to the CSP target villages in Baray-Santuk Operation District of Kampong Thom, Cambodia.

Background:
The CSP is implemented in three phases, with five Health Center (HC) catchment areas covered in Phase I and an additional five HC catchment areas added in Phase II. Phase III is a consolidation phase involving all ten HC catchment areas. The first two phases are using two different strategies in mobilizing and educating using village volunteers. For all HCs in the Phase I 5 HC catchment areas, a Commune Coordinator was chosen to direct and monitor village health volunteer (VHV) chiefs and VHVs in each HC catchment areas. The CCs improve and maintain VHV performance by example and direct mentorship. ADRA supports transportation allowances to the CCs, and non-financial incentives to the VHVs. However, the sustainability of this system is a never ending debate. It was then decided not to use CCs in the five additional HC catchment areas added during the second phase, and intensify the village health volunteer role giving them a new name of Community Health Educator (CHE). In addition to the non financial incentives still being received by the VHVs in the first 5 HC catchment areas, CHEs will receive a modest transportation allowance to cover increased travel costs and motivate CHE's in the more intense activities..

Purpose
This research is aiming to answer questions on which of the two community health volunteer systems is most beneficial for project impact, to improve health intervention effectiveness, for volunteer sustainability, and for volunteer performance. This research will also document a sustainability model of a community health volunteer and will provide documentation on how to work with village volunteers in most effective ways highlighting the differences of volunteers with and without stipends (travel allowance).

Research Design:
The research is a qualitative comparative study of two volunteer models. It will focus on comparisons such as:

1. Selection and recruitment of community health volunteers.
    1. more education versus less education

    2. older versus younger
2. Community health volunteer training activities.
3. The effect of financial versus non-financial incentives in encouraging volunteer participation.
4. The attrition rate
5. The rate of learning by the drip feeding method used with CHEs versus the longer and less frequent trainings given to the VHVs.
6. Impact of the expected workloads of volunteers on their commitments to the family and community.
7. The role of HC staff and HC Management Committee in supporting and monitoring community health volunteer, both outreach and HC based activities.
8. The effect of intensive capacity building with CCs on their future health worker potential.
9. The role of community health volunteers in Village Based Structures.
10. The ease of transitioning from VHV and CHE into the Village Health Support Group (VHSG) government supported structure of two persons per village by the end of the project including:
    1. The role of community health volunteers in data collection related to community-based death and diseases surveillance and how this process can be supported once the project ends.
    2. Feedback mechanism between CCs & VHVs and CHEs with HCs, ODs, Village & Commune Development Committees and local authorities, including Commune Councils and village chiefs.

7. Revised Project Indicators

PROGRAM GOALS AND OBJECTIVES - LOGICAL FRAMEWORK

Project Goal: To improve the quality of health and reduce th345e morbidity and mortality of children under five and women of reproductive age in the Baray-Santuk Operational District, Kampong Thom Province of the Kingdom of Cambodia.

OBJECTIVES	INDICATORS	MEASUREMENT METHODS	MAJOR PLANNED ACTIVITIES	ASSUMPTIONS
MATERNAL and NEWBORN CARE				
1. Reduce infant and maternal deaths by providing pre-/post-natal care and appropriate delivery practices.	1.1 Increase to 80%, HCMs able to provide quality basic pre-/post-natal and obstetric care.	▪ Training registers ▪ Competence/Skills assessment ▪ Supervision records of HCMs ▪ Health facilities assessments	▪ HC Assessment ▪ Train/Upgrade HCMs ▪ Establish supervision system ▪ Establish HIS ▪ Establish HC and community linkages	▪ Good working relationship with health facilities.
	1.2 80% of TBAs able to provide quality basic delivery care. 1.3 60% of pregnant women follow through with their TBA's referral.	▪ Training registers ▪ Competence/Skills assessment ▪ FU knowledge and skills testing ▪ Supervision records of TBAs ▪ HC records	▪ Select TBAs ▪ Train TBAs ▪ Establish supervision system ▪ Continue FU monthly meetings for refresher training and data collection ▪ Promote TBAs in the community ▪ TBAs engage in their work with new skills	▪ Women are inclined to go to the HCs
	1.3 Increase from 10% to 35% mothers of children less than 24 months who receive prenatal care at least two times during the pregnancy from trained HCMs.	▪ Baseline/Final surveys ▪ HC records	▪ Community awareness and promotion of MNC ▪ Establish HC and community linkages ▪ HCMs spend time with mothers explaining the importance of a plan	▪ HC and community relations strengthened.
	1.4 40% of pregnant women who have a birth preparedness plan.	▪ Final survey ▪ FGDs ▪ HC records		
	1.4 Women's TT coverage (see Immunizations Intervention)	▪ (see Immunizations intervention)	▪ (see Immunizations intervention)	▪ (see Immunizations intervention)

OBJECTIVES	INDICATORS	MEASUREMENT METHODS	MAJOR PLANNED ACTIVITIES	ASSUMPTIONS
	1.5 Increase from 70% to 80% use of clean birth kits at deliveries.	▪ Baseline/Final surveys ▪ HC records ▪ Post-delivery interviews ▪ FGDs	▪ Community awareness and promotion of safe delivery kits ▪ Conduct post-delivery interviews ▪ FU monthly meetings with TBAs for refreshers and data collection	▪
	1.6 **Increase from 25% to 80% children less than 24 months who were weighed at birth.**	▪ Baseline/Final surveys ▪ HC records	▪ Define protocol ▪ Train HCMs, TBAs and VHVs in weighing of newborns and protocol for LBWs ▪ Establish supervision system ▪ Community awareness and promotion of MNC ▪ Implement Baby Friendly Community Initiative	▪ Good working relations with health facilities. ▪ Affordable, sustainable supply of hand-held scales for TBAs will be located.
	1.7 LBW protocol practiced by mothers in 50% of cases where newborns weigh less than 2500 gms.	▪ HC records ▪ Supervision records of HCMs		▪ TBAs will have hand-held scales in kits.
	1.8 Initiation of breastfeeding (see Nutrition Intervention)	▪ (see Nutrition Intervention)	▪ (see Nutrition Intervention)	▪ (see Nutrition Intervention)
2. Reduce maternal deaths by improving access to emergency obstetric care.	2.1 30 target villages have established a functioning emergency obstetric referral plan.	▪ HIS records ← VDC records ▪ HC Committee minutes ▪ Documented cases of use ▪ FGDs	▪ Community awareness and promotion ▪ Facilitate community discussions in the establishment of an EOC plan	▪ Community members committed to adhering to plan. ▪ Emergency Obstetric Services are available within a reasonable travelling distance.
3. Raise awareness about the deadliness and prevention of HIV/AIDS.	**3.1 Increase from 5% to 85% mothers of children <2 years who know at least two ways that HIV/AIDS is spread.** 3.2 Increase from **57% (1st LQAS result)** to 85% men 15-65 who know at least two ways that HIV/AIDS is spread.	▪ Baseline/Final surveys ▪ FGDs	▪	▪
BIRTH SPACING				

OBJECTIVES	INDICATORS	MEASUREMENT METHODS	MAJOR PLANNED ACTIVITIES	ASSUMPTIONS
1. Families are making informed choices regarding birth spacing/the use of contraceptives.	1.1 Increase from 33% to 60% women receiving birth spacing methods and counselling at HC and community level.	▪ Training registers ▪ Competence/Skills Assessment ▪ Supervision records of HCMs ▪ HC exit interviews	▪ HC Assessment ▪ Train/Upgrade HCMs ▪ Establish supervision system ▪ Establish HIS ▪ Establish HC and community linkages ▪ Conduct exit interviews	▪ Good working relations with health facilities. ▪ Family planning methods will continue to be available at HCs.
	1.2 Increase from 18% to 60% mothers with children less than 24 months old who know three modern methods of birth spacing.	▪ Baseline/Final surveys ▪ FGDs	▪ Train VHVs and TBAs ▪ Community awareness and promotion of birth spacing ▪ VHVs organize and hold Mothers' Clubs	
2. WRA utilize birth spacing methods in a timely fashion and continuously	**2.1 Increase from 32% to 50% mothers with children less than 24 months old who desire no children in the next two years or do not know who use a modern contraceptive method.**	▪ Baseline/Final surveys ▪ HC records ▪ FGDs	▪ Train VHVs and TBAs ▪ Community awareness and promotion ▪ TBAs give key messages to pregnant mothers ▪ VHVs engage women in Mothers' Clubs ▪ Conduct post-delivery interviews ▪ FGDs with men and women	▪ Family planning methods are available and affordable to women who wish to use them.
	2.2 Increase from 25% to 35% mothers with children less than 24 months old who initiated use of modern method of birth spacing within the first three months following pregnancy.	▪ Baseline/Final surveys ▪ HC records ▪ Post-delivery interviews		
3. Families are successful in birth spacing plans.	3.1 Increase from 29% to 50% children <24 months whose next sibling is two or more years older.	▪ Baseline/Final surveys	▪ Community awareness and promotion of birth spacing ▪ VHVs organize and hold Mothers' Clubs	
NUTRITION				
1. To improve the nutritional status of infants through appropriate breast-feeding practices.	**1.1 Increase from 13% to 33% the number of mothers who initiate breastfeeding within the first hour after delivery.**	▪ Baseline/Final surveys ▪ HC records ▪ Post-delivery interviews ▪ Nutritional assessment ▪ FGDs	▪ Train hearth volunteers, VHVs and TBAs in breastfeeding promotion ▪ Community awareness and promotion ▪ TBAs and volunteer mothers give	
	1.2 Increase from 19% to 25%			

OBJECTIVES	INDICATORS	MEASUREMENT METHODS	MAJOR PLANNED ACTIVITIES	ASSUMPTIONS
	mothers with children less than 24 moths old who breastfeed exclusively up to 6 months after delivery.		key messages to pregnant mothers ▪ VHVs engage women in Mothers' Clubs ▪ Conduct post-delivery interviews	▪ Household food security
2. To improve the nutritional status of infants through consumption of nutritious foods.	**2.1 Increase from 12% to 32% mothers of children <2 who received increased fluids and continued feeding during an illness in the past two weeks**.	▪ Nutritional Assessment ▪ Baseline/Final surveys	▪ Train hearth volunteers, VHVs and AEs in nutrition health education and promotion ▪ Community awareness and promotion ▪ Selection of volunteer mothers ▪ Hearth cooking demonstrations implemented ▪ Home gardening activities and support from AEs ▪ VHVs engage women in Mothers' Clubs	▪ Household food security
3. To improve the malnutrition status of children <3 years of age.	3.1 Decrease from 42% to 32%, children <2 years of age who are underweight (-2 SD from the median wfa).	▪ Hearth Intervention Records ▪ LQAS surveys	▪ Train hearth volunteers in nutrition education and promotion ▪ Community awareness and promotion ▪ Selection of hearth volunteers ▪ Identification of malnourished children and enrollment in hearth activities ▪ Monthly GM activities of hearth participants	▪ Household food security
4. To decrease anemia in pregnant and lactating women.	**4.1 Increase from 33% to 50% of mothers with children less than 24 months old who report having received IFT supplements.**	▪ Baseline/Final surveys ▪ HC records	▪ Supervisory visits for HCMs during prenatal care visits ▪ Train TBAs in dangers of anemia and IFT distribution ▪ Ensure data collection system	▪ IFT supply reliable.
5. To improve the vitamin A status of women and children <5 years of age.	5.1 Increase from 35% to 60% children 6-23 mos of age who received at least one vitamin A capsule in the last 6 mos.	▪ Baseline/Final surveys ▪ FGDs	▪ Train hearth volunteers, VHVs, TBAs and AEs in vitamin A ▪ Community awareness and promotion	▪

OBJECTIVES	INDICATORS	MEASUREMENT METHODS	MAJOR PLANNED ACTIVITIES	ASSUMPTIONS
	5.2 Increase from 17% to 30% women who receive a VAC within 8 weeks postpartum.	▪ Baseline/Final surveys ▪ HC records	▪ VHVs and AEs include HE in Mothers' Clubs and home gardening activities ▪ Ensure that HC medical staff combine EPI activities with VAC distribution	▪ VAC supply reliable. ▪ Good working relations with health facilities.
6. Families are experiencing improved household food security through home gardening.	**6.1 Increase from 14% to 20% number of households with children less than 24 months who receive basic home gardening instruction/training.**	▪ Baseline/Final surveys ▪ FGDs ▪ Training records	▪ CS Project coordinates activities with AEs of ADRA's CBFS Project ▪ AEs promote home gardening ▪ AEs provide FU support for home gardening ▪ Ensure data collection system	
IMMUNIZATIONS				
1. Improved immunization coverage for children <2 years of age.	1.1 Increase from 28% to 60% children under 2 who have complete immunization coverage.	▪ **Baseline**	▪ Preliminary formative research on perceptions of six diseases, etc. ▪ HC assessments and strengthening of weaknesses (ie cold chain, vaccine, etc) ▪ Refresher training for HCMs ▪ Integrate EPI outreach with GMP in villages ▪ Implement community awareness and VHDs with GM/EPI campaigns	▪ Vaccine supplies reliable. ▪ HC staff motivated to participate in outreach activities.
2. Improved maternal TT vaccination coverage for the prevention of tetanus.	**2.1 Increase from 9% to 40% mothers with children less than 24 months who have at least two TT vaccinations before the birth of their youngest child.**	▪ Baseline/Final surveys (card confirmed) ▪ HC records	▪ Community awareness of the dangers of tetanus ▪ Ensure TT supplies at HCs ▪ Establish HC and community linkages ▪ HCMs take every opportunity at prenatal care visits to promote TT	▪ TT supplies reliable. ▪ Women are aware of need for TT vaccinations.
CAPACITY BUILDING				

OBJECTIVES	INDICATORS	MEASUREMENT METHODS	MAJOR PLANNED ACTIVITIES	ASSUMPTIONS
1. **CS Backstop Unit & CS Project Team:** Improved organizational learning related to health programs.	1.1 Standardized technical backstopping protocol includes standards for identification of innovative approaches and best practices that can be applied in other ADRA programs.	▪ Technical backstopping protocol document.	▪ CS staff trained to think laterally and innovatively and given the opportunity to learn through their mistakes and successes. ▪ CS staff given permission to test ideas, without negative consequences for approaches that do not elicit expected results ▪ Develop a standardized protocol for health project technical backstopping that includes standards for identification of innovative approaches and best practices. ▪ Innovative approaches and best practices documented at the CS Project Team level are entered into the electronic project tracking system. ▪ Innovative approaches and best practices are published internally. ▪ Technical backstop officer(s) promote(s) best practices and innovative approaches as feasible/appropriate throughout ADRA's health portfolio.	▪
	1.2 Lessons learned/innovative approaches from CSXVII are published internally.	▪ Electronic tracking system. ▪ Copy of internal newsletters.		▪ Electronic tracking system continues to be used by ADRA. ▪ ADRA country offices publish their own newsletters.
	1.3 Lessons learned/innovative approaches from CSXVII are published/presented in at least two publications/forums external to ADRA.	▪ Copy of publication. ▪ Transcript of presentation.		
	1.4 Documented lessons learned/best practices from CSXVII are applied to other ADRA health programs.	▪ Technical backstop officer trip reports. ▪ CSXVII mid-term and final evaluation.	▪ Techncial assistance provided in field visits. ▪ Trip report presentation at HPWG ▪ Sharing Lessons Learned with other CS projects.	▪

OBJECTIVES	INDICATORS	MEASUREMENT METHODS	MAJOR PLANNED ACTIVITIES	ASSUMPTIONS
2. **CS Project Team:** Improved technical knowledge and skills related to health project M&E.	2.1 LQAS system in place and functioning.	▪ Training register. ▪ LQAS forms. ▪ Project monitoring reports. ▪ Mid-term & final evaluations. ▪ Supervision records.	▪ Train CS project staff in LQAS. ▪ LQAS system adapted for country-specific CSXVII context. ▪ Project objectives and activities modified based on LQAS results. ▪ Special assistance/supervision provided to project staff as needed.	▪
SUSTAINABILITY				
1. Improved cost recovery for Health Centers in the BSOD Health Department	**1.1 Each Health Center has a customized fee for service schedule established by the respective Health Center Management Committee.** **1.2 Each Health Center in the project area has a posted fee schedule.**	*Outlined above*	*Outlined above*	
2. Increased responsibility of the BSOD Health Department and health centers	**2.1 The BSOD Health Department and Health Centers train and supervise village health volunteers (Village Health Support Group), and traditional birth attendants in methods of community education for health behavior change, within MOH policy.** **2.2 The BSOD Health Department and health centers train village health teams to implement selected interventions, such as Hearth Nutritional Rehabilitation, Safe Motherhood, and Child Spacing.**			

OBJECTIVES	INDICATORS	MEASUREMENT METHODS	MAJOR PLANNED ACTIVITIES	ASSUMPTIONS
3. Increased responsibility at the Health Center Management and/or Child Friendly Village Committee level	**3.1 Each Health Center has a management committee that carries out functions and participates in decision-making.** **3.2 Health Center Management and/or Child Friendly Village Committees have community health strategic plans that include:** **3.2.1. Motivation of village health volunteers and traditional birth attendants.** **3.2.2. Community health events, such as immunization days, growth monitoring/promotion, Hearth Nutritional Rehabilitation programs, community health fairs, etc...** **3.2.3. Periodic review of community health data for the purpose of community health planning.** **3.2.4. Advocacy with the health department and other stakehold3ers for community health needs.**			
4. Improved integration of community-based volunteer health promoters in the BSOD Health Department	**4.1 Standardized models volunteer training and supervision exist.** **4.2. Health Center Midwives, Village Health Volunteers, Traditional Birth Attendants, and some members of Health Center Management and/or Child Friendly Village Committees coordinate their efforts in health activities at the village level.**			

8. Revised Sustainability Action Plan

Objectives	Indicators	Activities	Responsibility	Date
1. Improved cost recovery for Health Centers in the BSOD Health Department	1.1 Each Health Center has a customized fee for service schedule established by the respective Health Center Management Committee.	Facilitate the development of HCs fee for service schedule.	HC Coordinator	February 2004 – December 2004
	1.2 Each Health Center in the project area has a posted fee schedule.	Promote the use of the fee schedule at the HC level.	HC Coordinator	June 2004 – EOP
2. Increased responsibility of the BSOD Health Department and health centers	2.1 The BSOD Health Department and Health Centers train and supervise village health volunteers (Village Health Support Group), and traditional birth attendants in methods of community education for health behavior change, within MOH policy.	OD supervise health centers HC staff meet regularly with TBAs, CHEs HC Midwife supervise CBD	OD director, vice director HC Chief and HCMs 2 BSO and HC midwives	Every two months Every month Every month
	2.2 The BSOD Health Department and health centers train village health teams to implement selected interventions, such as Hearth Nutritional Rehabilitation, Safe Motherhood, and Child Spacing.	Train CBD on birth spacing TBAs training (Safe motherhood, birth spacing, HIV/AIDS and STD); refreshers done monthly CHEs training (Safe motherhood, birth spacing, common diseases, HIV/AIDS and STD); refreshers done monthly Train Hearth volunteers and CHEs working in the 10 CFVs in nutrition health education and promotion; refresher after 6 months	OD-MCH program Officer HCMs and ODMCH HCC and ODMCH HCCs and ODMCH	June 2004 June & Nov 2004; Jan & Apr 2005 July & Dec 2004; Feb & May 2005 Aug & Sept 2004 Feb & Mar 2005
3. Increased responsibility at the Health Center Management and/or Child Friendly Village Committee level	3.1 Each Health Center has a management committee that carries out functions and participates in decision-making.	HCMC carry out Periodically review the community health data for the purpose of community health planning.	HC coordinator and Field team	Every 2 months
	3.2 Health Center Management and/or Child Friendly Village Committees have community health strategic plans that include:	CS staff will encourage HCMC and CFVC to develop community health strategic plan. Staff in house training for	HC Coordinator Officer CS staff	Every 2 months starting August July 2004

	3.2.1. Motivation of village health volunteers and traditional birth attendants.	strategic planning HC service Free of charge Encourage/recognize VHV/CHE who are successful as CBD Recognition scheme for best TBA, VHV/CHE	 HC and OD HCMC chief and CFVC chief CS Staff, HCMC and CFVC	 When needed October 2004 and February 2005 November 2005 during Village traditional celebration
	3.2.2. Community health events, such as immunization days, growth monitoring/promotion, Hearth Nutritional Rehabilitation programs, community health fairs, etc...	HCMCs &CFVCs involve in the field activities such as hearth, mother club, village health day, home gardening, EPI outreach with volunteers	HCMC&CFVC chief	Every month
	3.2.3. Periodic review of community health data for the purpose of community health planning	Make Community Health Data available to HCMC and CFVC	VHV, TBA, CS staff	Every 2 months
	3.2.4. Advocacy with the health department and other stakehold3ers for community health needs.	HCMC, CFVC chiefs and HC coordinator Officer consultation visit to the OD/PHD or other stakeholders.	HCMC, CFVC chiefs, HC Coordinator officer.	When needed
4. Improved integration of community-based volunteer health promoters in the BSOD Health Department	4.1 Standardized models volunteer training and supervision exist.	Standardizing ADRA existing Volunteer training and supervision manual with Rural Development Office and Health Department office in BSOD	PM, Director of Rural Development office, OD chief, PHD	Sep 2004
	4.2. Health Center Midwives, Village Health Volunteers, Traditional Birth Attendants, and some members of Health Center Management and/or Child Friendly Village Committees coordinate their efforts in health activities at the village level.	Integrated Village Health Day	HCMC, CFVC chiefs, HC coordinator officer, VHV/CHE Chief, CS staff	Oct 2004 and monthly to the end of the project.

9. MSC August Report

ADRA Cambodia Child Survival Project Baray-Santuk Operational District Most Significant Change Stories	
Domain:	Behavior change
Observation: Interview:	☑
Project:	Community Based Distribution Resource Network
Writer's name:	Mrs. Chan Bophan
Date of report (Day/Month/Year):	August 27,2004
Name of Village, health center and district:	Tadouk, Balaing and Baray
What is your name? (Mr./Mrs. first name and family name)	Pom Reng
How old are you?	35 years
Basic idea of change:	For me, using birth spacing method is better than abortion
What happened?	Multiple abortions by untrained TBA
When did the change happen?	June 2004
Details of the change: (HOW and Why did the change happen?)	Since before I myself always got pregnant without desire. I had no way to avoid this, thus every fetus was aborted as much as possible by an untrained traditional birth attendant (TBA). After that I have learned from CBDs who were trained by ADRA about complications of abortion between using birth spacing methods. I accepted birth spacing methods to avoid pregnancy.
How did ADRA help with this change?	ADRA actively trained existing VHVs to be CBDs and has provided birth spacing methods every month to CBDs to sell.
Only for stories from villagers. Why is this change important to the VILLAGER (person in story)?	I thought that when I have used birth spacing method the villagers will be surprised because I do this for a long time.
As a project staff member, why is this change important to you? Is it positive or negative?	*Still to be processed*
PMC reason why:	*Still to be processed*
ADRA Administration reason why[3]	
ADRA Headquarter reason for selection: *(Only for one story selected in each domain)*	*Still to be processed*

ADRA Child Survival Project Baray-Santuk Operational District Most Significant Change Stories	
Domain:	Health change
Observation: Interview:	☑
Project:	Child Survival
Person reporting:	Mrs. Ven Sopheap
Date of report (Day/Month/Year):	August 31, 2004
Name of Village, health center and district:	Trodork pong, Tang Kork, Baray
What is your name? (Mr./Mrs. first name and family name)	Yann Yen
How old are you?	72 years
Basic idea of change:	Drinking boiled water
What happened?	Boiled water is better than water without boiling
When did the change happen?	Oct 2000
Details of the change: (HOW and Why did the change happen?)	In the past my family never drunk boiled water and during that time they often had diarrhea, especially Aunt Yan Yen. Now my family has drunk boiled water so the occurrence not as before. This is that why my family has understood the health messages from ADRA trained volunteers and either radio and VT broadcaster.
How did ADRA help with this change?	ADRA staff discussed with trained volunteers (TBAs, VHVs) to find out the community problems to be solved related to the health educational situation to fit the community needs such as target group, what topics to be taught?, when education taken place?, where available possible?, how to educate? Villagers.
Only for stories from villagers. Why is this change important to the VILLAGER (person in story)?	Every so often, less expense, and healthy
As a project staff member, why is this change important to you? Is it positive or negative?	Boiling water is important because it kills the germs from water that come into the body through the mouth and also people can avoid many diseases that could be transmitted through unboiled water (typhoid fever, dysentery etc.).
PMC reason why:	*Still to be processed*
ADRA Administration reason why[3]	*Still to be processed*
ADRA Headquarter reason for selection: *(Only for one story selected in each domain)*	*Still to be processed*

10. Child Friendly Village Indicators

The staff has learned that CFVC members have difficulty in understanding and translating the CFV initiative to action plan. CS staff had given assistance during this process. A specific action plan was designed to develop specific indicators which village needs to improve, while reviewing plans for achievement on other indicators.

Revised CFV indicators were produced during this meeting, and CFVC work plan was developed by staff. Presently there are ten Child Friendly Village Committee established; each will work to improve village health status on these revised health indicators:

Child Friendly Village Indicators

Village:

- Village has a functioning Child Friendly Village Committee
- CFVC have developed action plan
- Community has established an emergency obstetric transport system

Children:

- Increase from 28% to 40% children <2 who have complete immunization coverage.
- Increase from 13% to 25% the number of mothers who initiate breastfeeding with colostrum within the first hour after delivery.
- Increase to 25% mothers of children <2 who continue giving water and food to children with illness.
- Decrease by 10% children age 0-23 months who are underweight (-2 s.d. for median Weight for Age).

Mother:

- Increase to 40% mothers of children <24 months who use a modern contraceptive method.
- Increase to 25% pregnant women who receive prenatal care at least two times during the pregnancy from trained HCMs.
- 25% of pregnant women have a birth preparedness plan